State: *District of Columbia* ***Filing Company:*** *Thrivent Financial for Lutherans*
TOI/Sub-TOI: *H11I Individual Health - Disability Income/H11I.008 Combined Short Term and Long Term - Unrelated to marketing with employer or association groups*
Product Name: *Individual Disability Income*
Project Name/Number: *G-Series/*

Filing at a Glance

Company:	Thrivent Financial for Lutherans
Product Name:	Individual Disability Income
State:	District of Columbia
TOI:	H11I Individual Health - Disability Income
Sub-TOI:	H11I.008 Combined Short Term and Long Term - Unrelated to marketing with employer or association groups
Filing Type:	Form
Date Submitted:	09/02/2015
SERFF Tr Num:	THRV-130042399
SERFF Status:	Assigned
State Tr Num:	
State Status:	
Co Tr Num:	
Implementation Date Requested:	
Author(s):	Bonnie Foley, Susan Schmidt
Reviewer(s):	Colin Johnson (primary)
Disposition Date:	
Disposition Status:	
Implementation Date:	

State: District of Columbia **Filing Company:** Thrivent Financial for Lutherans
TOI/Sub-TOI: H11I Individual Health - Disability Income/H11I.008 Combined Short Term and Long Term - Unrelated to marketing with employer or association groups
Product Name: Individual Disability Income
Project Name/Number: G-Series/

General Information

Project Name: G-Series
Project Number:
Requested Filing Mode:
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Bonnie Foley

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 09/02/2015
State Status Changed:
Created By: Bonnie Foley
Corresponding Filing Tracking Number:

Filing Description:

H-IN-NCDI (15)Noncancellable Disability Income Insurance Contract
H-IG-GRDI (15)Guaranteed Renewable Disability Income Insurance Contract

HR-IF-FPO (15)Future Purchase Option Benefit Rider
HR-IF-3 (15)Future Purchase Option Benefit Rider Schedule Page
HR-IX-COL (15) Cost of Living Indexing Benefit Rider
HR-IX-3 (15)Cost of Living Indexing Benefit Rider Schedule Page
HR-IO-SIO (15) Social Insurance Offset Benefit Rider
HR-IO-3 (15)Social Insurance Offset Benefit Rider Schedule Page
HR-IU-SDI (15)Supplemental Disability Income Benefit Rider
HR-IU-3 (15)Supplemental Disability Income Benefit Rider Schedule Page
HR-IR-RDI (15)Residual Disability Benefit Rider
HR-IR-3 (15)Residual Disability Benefit Rider Schedule Page

28848 Individual Disability Income Insurance Application
28849 Simplified Issue Individual Disability Income Insurance Application
28855 Supplement to Application for Insurance – Medical Details
28857 Conditional Temporary Individual Disability Income Insurance Agreement and Receipt for Payment
28858 Supplement to Application for Insurance - Prescription Drugs
28859 Supplement to Application for Insurance – Replacement and Other Coverage
28861 Endorsement Eliminating Coverage
28872 Disability Income Application Change
28874 Statement of Good Health
28875 Supplement to Application for Insurance – Application Action
28876 Supplement to Application for Insurance – Moving Traffic Violations
28877 Individual Disability Income Insurance Contract Reinstatement Application

28883 N5-15 Outline of Coverage
28882 N5-15 Outline of Coverage

The above captioned forms are submitted for your review and approval. These forms are new and for use with this product and will replace our current Disability Income forms DC12124, DC12125 et al which were filed on 7/11/2000.

Form H-IN-NCDI (15) Noncancellable Disability Income Insurance Contract

State: District of Columbia **Filing Company:** Thrivent Financial for Lutherans
TOI/Sub-TOI: H11I Individual Health - Disability Income/H11I.008 Combined Short Term and Long Term - Unrelated to marketing with employer or association groups
Product Name: Individual Disability Income
Project Name/Number: G-Series/

This is a new disability income contract that is noncancellable to the contract anniversary on or after the insured's age 67 and conditionally renewable thereafter to the contract anniversary on or after the insured's age 75. It will be available for new sales. It contains a total disability benefit as well as a partial disability benefit. Issue ages available are 18-60. The minimum issue limit for new business is $500 per month.

Form H-IG-GRDI (15) Guaranteed Renewable Disability Income Insurance Contract
This disability income contract will not be available for new sales at this time. This form and the associated rates are currently developed for use with contract holders of our DI product on which new sales were discontinued on 1/1/2003. Due to our systems limitations, when an insured with one of these existing contracts exercises an FPO, we need to issue a new guaranteed renewable contract for the exercised FPO piece. This is currently the only situation where we plan to issue this contract.

Form HR-IF-FPO (15) Future Purchase Option Benefit Rider
Form HR-IF-3 (15) Future Purchase Option Benefit Rider Schedule Page
This rider permits the insured to increase the amount of coverage on certain dates without medical evidence of insurability. Financial underwriting is required.

Form HR-IX-IDI (15) Cost of Living Indexing Benefit Rider
Form HR-IX-3 (15) Cost of Living Indexing Benefit Rider Schedule Page
During a disability, this rider adjusts monthly benefits with benefit periods of 60 months or longer by changes in the Consumer Price Index for All Urban Consumers.

Form HR-IO-SIO (15) Social Insurance Offset Benefit Rider
Form HR-IO-3 (15) Social Insurance Offset Benefit Rider Schedule Page
During a disability, this rider pays a monthly benefit when disability benefits under social insurance programs are not paid or are less than the social insurance offset maximum monthly benefit amount.

Form HR-IU-SDI (15) Supplemental Disability Income Benefit Rider
Form HR-IU-3 (15) Supplemental Disability Income Benefit Rider Schedule Page
This rider pays an additional monthly benefit while the insured is disabled.

Form HR-IR-RDI (15) Residual Disability Benefit Rider
Form HR-IR-3 (15) Residual Disability Benefit Rider Schedule Page
During a disability, this rider pays a proportion of the monthly benefit based on the portion of lost earnings compared to prior earnings. Loss of earnings must be at least 20% but less than 80% of prior earnings.

Form 28848 Individual Disability Income Insurance Application
This application will be used to apply for a disability income insurance contract and optional riders. This application will also be used to request changes on in-force contracts. If additional space is needed for entering information for things such as medical details, prescription drugs, etc; there are separate supplements submitted in this filing for this purpose.

Form 28849 Simplified Issue Individual Disability Income Insurance Application
This application will be used to apply for a disability income insurance contract on form H-IN-NCDI (15) with limited benefits/coverage using a simplified underwriting process in conjunction with a qualifying life insurance contract.

Form 28855 Supplement to Application for Insurance – Medical Details
This supplement form will be used with application form 28848 when additional space is needed for entering information in

section 9 concerning medical details.

Form 28857 Conditional Temporary Individual Disability Income Insurance Agreement and Receipt for Payment
This form will be used when applying for a disability income insurance contract and the first full premium is collected with the application.

28858 Supplement to Application for Insurance - Prescription Drugs
This supplement form will be used with application form 28848 when additional space is needed for entering information in response to question 7(d) concerning prescription drugs.

28859 Supplement to Application for Insurance – Replacement and Other Coverage
This supplement form will be used with application form 28848 when additional space is needed for entering information in response to questions in section 2 concerning replacement and other coverage.

28861 Endorsement Eliminating Coverage
This form will be used to limit or exclude coverage(s) based on information disclosed by the insured in the application or identified during the underwriting process.

28872 Disability Income Application Change
This form will be used to verify, change or correct information contained in the application forms 28848, 28849, and 28877.

28874 Statement of Good Health
This form will be used with the Application forms 28848 and 28849 whenever no premium is collected at time of application. It includes medical questions to update insurability from the date of application to the date the premium is collected.

28875 Supplement to Application for Insurance – Application Action
This supplement form will be used with application form 28848 when additional space is needed for entering information in response to question 1(d) concerning application action.

28876 Supplement to Application for Insurance – Moving Traffic Violations
This supplement form will be used with application form 28848 when additional space is needed for entering information in response to question 1(c) concerning moving traffic violations.

28877 Individual Disability Income Insurance Contract Reinstatement Application
This application will be used to apply for reinstatement of a disability income contract that has lapsed due to non-payment of premium.

28883 N3-15 Outline of Coverage
The agent/producer will deliver this form to the applicant at time of application. For use with form H-IN-NCDI (15) Noncancellable Disability Income Insurance Contract.

28882 N3-15 Outline of Coverage
The agent/producer will deliver this form to the applicant at time of application. For use with form H-IG-GRDI (15) Guaranteed Renewable Disability Income Insurance Contract.

Applications
The application software on each representative’s computer is secure and cannot be altered by the agent. Applications may

be electronically submitted to our home office or may be printed, signed, and mailed to us. When an electronic application is completed and has been reviewed with the applicant, all necessary signatures are captured electronically and transmitted as part of the application. Signatures are encrypted and cannot be transferred or used for any other purpose. If any changes are made to the application after the signature has been processed, the signature is erased and the entire application must be reviewed and signed again. The electronic signature, as defined in your state's electronic signature laws, complies with both federal Electronic Signatures in Global and National Commerce Act (E-Sign Act) and state electronic signature laws. In all cases, a printed copy of the signed application will be included in the contract at time of issue.

Changes in Format
The forms submitted for review and approval are in final printed form. Minor modifications could occur in format, such as word wrap, pagination or balancing text on a page. However, the wording of the forms will not be changed.

Marketing
This contract will be offered by agents/producers appointed to represent Thrivent Financial for Lutherans to individuals meeting membership eligibility requirements (issue ages 18-60).

The Actuarial Memorandum and rates are being submitted separately under SERFF filing number THRV-130042398.

Company and Contact

Filing Contact Information

Bonnie Foley, Contract Forms & Compliance Specialist III
625 Fourth Ave S
Minneapolis, MN 55415-1665

bonnie.foley@thrivent.com

612-844-8623 [Phone]
612-844-5040 [FAX]

Filing Company Information

Thrivent Financial for Lutherans
4321 North Ballard Road
Appleton, WI 54919-0001
(800) 847-4836 ext. [Phone]

CoCode: 56014
Group Code: 2938
Group Name:
FEIN Number: 39-0123480

State of Domicile: Wisconsin
Company Type: Fraternal
State ID Number:

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

SERFF Tracking #: THRV-130042399 **State Tracking #:** **Company Tracking #:**

State: District of Columbia **Filing Company:** Thrivent Financial for Lutherans
TOI/Sub-TOI: H11I Individual Health - Disability Income/H11I.008 Combined Short Term and Long Term - Unrelated to marketing with employer or association groups
Product Name: Individual Disability Income
Project Name/Number: G-Series/

Form Schedule

Lead Form Number: H-IN-NCDI (15)

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Noncancellable Disability Income Insurance Contract	H-IN-NCDI (15)	POL	Initial			H-IN-NCDI (15) bracket for DC.pdf
2		Guaranteed Renewable Disability Income Insurance Contract	H-IG-GRDI (15)	POL	Initial			H-IG-GRDI (15) bracket for DC.pdf
3		Future Purchase Option Benefit Rider	HR-IF-FPO (15)	POLA	Initial			HR-IF-FPO (15).pdf
4		Future Purchase Option Benefit Rider Schedule Page	HR-IF-3 (15)	SCH	Initial			HR-IF-3 (15).pdf
5		Cost of Living Indexing Benefit Rider	HR-IX-COL (15)	POLA	Initial			HR-IX-COL (15).pdf
6		Cost of Living Indexing Benefit Rider Schedule Page	HR-IX-3 (15)	SCH	Initial			HR-IX-3 (15).pdf
7		Social Insurance Offset Benefit Rider	HR-IO-SIO (15)	POLA	Initial			HR-IO-SIO (15).pdf
8		Social Insurance Offset Benefit Rider Schedule Page	HR-IO-3 (15)	SCH	Initial			HR-IO-3 (15).pdf
9		Supplemental Disability Income Benefit Rider	HR-IU-SDI (15)	POLA	Initial			HR-IU-SDI (15).pdf
10		Supplemental Disability Income Benefit Rider Schedule Page	HR-IU-3 (15)	SCH	Initial			HR-IU-3 (15).pdf
11		Residual Disability Benefit Rider	HR-IR-RDI (15)	POLA	Initial			HR-IR-RDI (15).pdf
12		Residual Disability Benefit Rider Schedule Page	HR-IR-3 (15)	SCH	Initial			HR-IR-3 (15).pdf
13		Individual Disability Income Insurance Application	28848	AEF	Initial			28848.pdf

SERFF Tracking #: THRV-130042399 **State Tracking #:** **Company Tracking #:**

State: District of Columbia **Filing Company:** Thrivent Financial for Lutherans
TOI/Sub-TOI: H11I Individual Health - Disability Income/H11I.008 Combined Short Term and Long Term - Unrelated to marketing with employer or association groups
Product Name: Individual Disability Income
Project Name/Number: G-Series/

Lead Form Number: H-IN-NCDI (15)

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
14		Simplified Issue Individual Disability Income Insurance Application	28849	AEF	Initial			28849.pdf
15		Supplement to Application for Insurance – Medical Details	28855	AEF	Initial			28855.pdf
16		Conditional Temporary Individual Disability Income Insurance Agreement and Receipt for Payment	28857	AEF	Initial			28857.pdf
17		Supplement to Application for Insurance - Prescription Drugs	28858	AEF	Initial			28858.pdf
18		Supplement to Application for Insurance – Replacement and Other Coverage	28859	AEF	Initial			28859.pdf
19		Endorsement Eliminating Coverage	28861	POLA	Initial			28861.pdf
20		Disability Income Application Change	28872	AEF	Initial			28872.pdf
21		Statement of Good Health	28874	AEF	Initial			28874.pdf
22		Supplement to Application for Insurance – Application Action	28875	AEF	Initial			28875.pdf
23		Supplement to Application for Insurance – Moving Traffic Violations	28876	AEF	Initial			28876.pdf

SERFF Tracking #: THRV-130042399 **State Tracking #:** **Company Tracking #:**

State: District of Columbia **Filing Company:** Thrivent Financial for Lutherans
TOI/Sub-TOI: H11I Individual Health - Disability Income/H11I.008 Combined Short Term and Long Term - Unrelated to marketing with employer or association groups
Product Name: Individual Disability Income
Project Name/Number: G-Series/

Lead Form Number: H-IN-NCDI (15)

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
24		Individual Disability Income Insurance Contract Reinstatement Application	28877	AEF	Initial			28877.pdf
25		Outline of Coverage	28883 N5-15	OUT	Initial			28883 N5-15.pdf
26		Outline of Coverage	28882 N5-15	OUT	Initial			28882 N5-15.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

THRIVENT FINANCIAL®

Thrivent Financial for Lutherans
A Fraternal Benefit Society • Appleton, Wisconsin 54919-0001

DISABILITY INCOME INSURANCE

This certificate of membership and disability income insurance is a legal contract between you and Thrivent Financial for Lutherans. We issue this contract based on the Application signed by the applicant and the payment of the initial premium shown on page 3. We will pay benefits according to the provisions of this contract. Coverage starts at 12:01 a.m. on the Date of Issue. It ends at 11:59 p.m. on the day this contract terminates.

This contract is noncancellable to age 67. You may keep this contract in force until the Contract Anniversary on or after your 67th birthday by paying premiums when due. Except for our limited right to increase premiums for the Social Insurance Offset Benefit rider, if any, we cannot change the premiums stated on page 3.

Conditionally Renewable to age 75. You may keep this contract in force on a limited basis beyond the Contract Anniversary on or after your 67th birthday (see Section 8.10).

Right to Cancel. Please read this contract carefully. You may cancel this contract for any reason before midnight of the 30th day after you first receive it. Do this by returning this contract to us at our Service Center or to the representative through whom you bought it. Return of the contract by mail is effective on being postmarked, properly addressed and postage prepaid. If you cancel the contract, it will be deemed void from the beginning and the parties will be in the same position as if no contract had been issued. We will refund all premiums paid, including any policy fees or other charges.

Important Notice - Statements in the Application. Please read the copy of the Application attached to this contract. This contract was issued on the basis that all information shown in the Application is correct and complete. Omissions or misstatements in the Application could cause a claim to be denied or make this contract void. If any information shown is not correct or complete or if any past medical history has been left out of the Application or information about other disability income coverage has been misstated, contact us immediately.

Disability Income Insurance.
Noncancellable to age 67.
Conditionally renewable to age 75.
Pre-existing Condition limitations or exclusions and other limitations or exclusions may apply. Please read your contract carefully.
Annual dividends payable if earned.

Service Center:
Thrivent Financial for Lutherans
4321 North Ballard Road
Appleton, WI 54919-0001

Telephone (800) 847-4836
www.thrivent.com

Signed for the Society

President Bradford L Hewitt

Secretary Teresa J Rasmussen

INSURED: JOHN DOE AGE: 35 SEX: MALE

CONTRACT NUMBER: H0012345 DATE OF ISSUE: JUNE 1, 2015

Contract Number: [ ]

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THRIVENT
FINANCIAL®
Thrivent Financial for Lutherans
4321 N. Ballard Road, Appleton, WI 54919-0001

Contract Schedule

	ANNUAL PREMIUM
BASIC BENEFIT	
DISABILITY INCOME INSURANCE	
PREMIUM FOR BASIC BENEFIT PAYABLE TO AGE 67	[$127.60]*
OCCUPATIONAL CLASS: [4A]	
TOBACCO STATUS: [NON-TOBACCO]	
PREMIUM RATING: [STANDARD]	
MONTHLY BENEFIT: [$1,000]	
ELIMINATION PERIOD: [3 MONTHS]	
BENEFIT PERIOD: [60 MONTHS]+	
ADDITIONAL BENEFITS	
DETAILS OF THE FOLLOWING ADDITIONAL BENEFIT RIDERS ARE GIVEN ON SEPARATE SCHEDULE PAGES:	
FORM ICC15 HR-IF-FPO	$41.62
FORM ICC15 HR-IO-SIO	$111.10
FORM ICC15 HR-IR-RDI	$37.84
FORM ICC15 HR-IU-SDI	$127.60
FORM ICC15 HR-IX-COL	$12.10
TOTAL ANNUAL PREMIUM	[$457.86]
INTERVAL OF PAYMENT	[ANNUAL]
INITIAL PREMIUM	[$457.86]

* RENEWAL OF COVERAGE BEYOND AGE 67 MAY REQUIRE AN INCREASE IN PREMIUM AFTER AGE 67. SEE SECTION 8.10 CONDITIONALLY RENEWABLE TO AGE 75.

+[BUT NOT BEYOND AGE 67. HOWEVER, IF YOU ARE DISABLED AT AGE 67 AND LESS THAN 12 MONTHS OF BENEFIT HAVE BEEN PAID, THE BENEFIT PERIOD WILL BE 12 MONTHS.] MONTHLY BENEFITS FOR MENTAL / NERVOUS DISORDERS, SUBSTANCE ABUSE / CHEMICAL DEPENDENCY AND SELF-REPORTED SYMPTOMS ARE LIMITED AS DESCRIBED IN SECTIONS 5.2 AND 5.3.

"AGE 67" MEANS THE CONTRACT ANNIVERSARY ON OR AFTER YOUR 67TH BIRTHDAY.

THIS CONTRACT IS ELIGIBLE FOR ANNUAL DIVIDENDS, BUT DIVIDENDS ARE NOT GUARANTEED.

THE INSURANCE DEPARTMENT OF THE STATE IN WHICH THIS CONTRACT WAS ISSUED MAY BE CONTACTED BY CALLING [(999) 999-9999].

INSURED: [JOHN DOE] AGE: [35] SEX: [MALE]

CONTRACT NUMBER: [H0012345] DATE OF ISSUE: [JUNE 1, 2015]

1. DEFINITIONS

Application. The application(s) and all application supplements and amendments to the Application.

Benefit Period. The maximum number of months for which we will pay benefits for any Separate Period of Disability. The Benefit Period begins at the end of the Elimination Period.

Complications of Pregnancy. Physical conditions considered distinct from pregnancy even though caused or aggravated by pregnancy, including non-elective Caesarean section, miscarriage, ectopic pregnancy, eclampsia, gestational diabetes, toxemia, and nephritis.

Complications of Pregnancy do not include morning sickness, false or pre-term labor, occasional spotting, rest prescribed by a Doctor, or similar conditions related to the management of a difficult pregnancy but not classified as Complications of Pregnancy.

Contract Anniversary. The same month and day of each year after issue as in the Date of Issue of this contract.

Contract Year. The first Contract Year is the period of time from the Date of Issue until the first Contract Anniversary. Thereafter, Contract Year is the period of time from one Contract Anniversary to the next Contract Anniversary.

Date of Issue. The Date of Issue of this contract as shown on page 3.

Disability. A Partial Disability or Total Disability.

Disabled. You have a Partial Disability or a Total Disability.

Doctor. A person legally licensed to practice medicine or psychology and acting within the scope of his or her license, or a health care practitioner who is legally licensed, and is acting within the scope of his or her license, to treat an Injury or Sickness causing Disability. When Disability is caused by a Mental/Nervous Disorder, Doctor means a licensed psychiatrist or a licensed doctoral-level psychologist.

Doctor may not include you, any person related to you by blood or marriage, any person who shares a significant business interest with you, or any person who is a partner in a legally sanctioned domestic partnership or civil union with you.

Doctor's Care. The regular and personal care of a Doctor that, under prevailing medical standards, is:

1) Appropriate for the Sickness or Injury causing the Disability; and

2) Intended to help you return to the material and substantial duties of your Regular Occupation or gainful employment in any Occupation.

Elimination Period. The number of days at the beginning of each Separate Period of Disability for which no monthly Disability benefits are payable. The Elimination Period starts on the first day you are Disabled. The number of days of Disability need not be consecutive, but must occur within a period of no more than two times the Elimination Period.

Gainful Occupation. An Occupation you perform for wage or profit.

Homemaker. Homemaker is an Occupation in which you perform regular household duties without remuneration, and are working fewer than 10 hours per week in a Gainful Occupation.

Hospital. An institution that is licensed as a Hospital by the proper authority of the state in which it is located. Hospital does not include:

1) Any institution, or part thereof, that is used primarily as a clinic, convalescent home, rest home, home for the aged, nursing home; or

2) Any facility primarily affording custodial, educational or rehabilitative care.

Injury. Bodily injury resulting from an accident, independent of all other causes, that occurs while this contract is in force. If Disability occurs more than 30 days after your injury, the condition will be considered a Sickness.

Insured. The person named as Insured on page 3.

1. DEFINITIONS (continued)

Mental / Nervous Disorder. A disorder that is classified as a mental or nervous disorder in the Diagnostic and Statistical Manual of Disorders (DSM) published by the American Psychiatric Association. We will use the DSM which is current at the time disability begins. If this manual is discontinued or replaced, we will use the appropriate manual in use by the American Psychiatric Association or its successor at the time disability begins.

Monthly Benefit. The monthly amount we will pay for a period of Total Disability. This amount is also used to calculate Partial Disability Benefits and Residual Disability Benefits, if any.

Notice. A request signed by you or provided in another manner acceptable to us and received in good order by us at our Service Center.

Occupation. A job, position or professional calling for which a person receives or could receive remuneration.

Partial Disability. A disability of the Insured:

1) That results from an Injury or Sickness;
2) That requires Doctor's Care for which we may periodically require a Doctor's report to support a claim of Disability; and
3) Due to which you are able to work in your Regular Occupation for at least 20%, but no more than 80%, of the time that you worked before your Sickness or Injury.

Partial Disability does not include the inability to work in your Regular Occupation due to:

1) Unemployment;
2) Loss of job; or
3) Job unsuitability not caused by Sickness or Injury.

Partially Disabled. You have a Partial Disability as defined above.

Pre-existing Condition. A condition for which:

1) Medical advice or treatment was recommended by a Doctor or received from a Doctor within the two-year period preceding the Date of Issue; or
2) Symptoms existed that would cause a person to seek diagnosis, care or treatment within the one-year period preceding the Date of Issue.

Regular Occupation. Regular Occupation is your Occupation at the time a Disability begins or another Occupation requiring similar skills or duties. If you are a Homemaker at the time Disability begins, that is your Regular Occupation. If the Occupational Class shown on page 3 is 1A or 2A, as of 2 years after the Disability began and while that period of Disability continues, Regular Occupation means any Occupation for which you are or you become reasonably suited by training, education, or experience.

Self-Employed. You are Self-Employed if you are the owner of a sole-proprietorship, a partner in a partnership, a member in a limited liability company, a shareholder in a closely held non-public corporation or a business owner in other legal business entities.

Self-Reported Symptoms. Symptoms of Sickness or Injury, which you report to your Doctor, that are not verifiable by objective medical means. Examples of Self-Reported Symptoms include (but are not limited to) headache, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness, and loss of energy.

1. DEFINITIONS (continued)

Separate Periods of Disability. Each Separate Period of Disability has both a new Elimination Period and a new Benefit Period. Periods of disability are separate if:

1) The later period of disability begins after a continuous period of 6 months for which no monthly Disability benefits are payable under this contract and:

   a) You work in a Gainful Occupation for at least 30 hours per week during that entire period; or

   b) If your Regular Occupation was not a Gainful Occupation when Disability began, you perform all of the substantial duties of that Regular Occupation during that entire period; or

2) The disability in a later period:

   a) Results from a cause that is unrelated to the cause or causes of the disability in a prior period; and

   b) Begins after you work in a Gainful Occupation for at least 30 hours per week for a continuous period of 30 days for which no monthly Disability benefits are payable under this contract.

Service Center. The Service Center address is shown on page 1.

Sickness. An illness or disease that first manifests itself while this contract is in force. Sickness includes:

1) Transplant of a part of your body to the body of another while this contract is in force; and

2) Complications of Pregnancy that first manifest themselves while your contract is in force. We will accept a Doctor's diagnosis of Complications of Pregnancy.

Substance Abuse / Chemical Dependency. The misuse of or dependence on any legal or illegal drug(s) or chemical(s), or controlled substance(s), including but not limited to alcohol, marijuana, cocaine, barbiturates, and narcotics. This definition does not apply to the use of medications that are taken as prescribed by a Doctor.

Total Disability. A disability of the Insured:

1) That results from an Injury or Sickness;

2) That requires Doctor's Care for which we may periodically require a Doctor's report to support a claim of Disability;

3) Due to which:

   a) You are unable to perform the material and substantial duties of your Regular Occupation; or

   b) You are able to work in your Regular Occupation but only for less than 20% of the time that you worked before your Sickness or Injury; and

4) During which you are not engaged in any Gainful Occupation other than in your Regular Occupation on a limited basis as described in 3(b) above.

Total Disability does not include the inability to perform duties due to:

1) Unemployment;

2) Loss of job; or

3) Job unsuitability not caused by Sickness or Injury.

Totally Disabled. You have a Total Disability.

we, our, us, Society. Thrivent Financial for Lutherans.

you, your and yours. The Insured named on page 3.

2. DISABILITY BENEFITS

The Monthly Benefit, Elimination Period and Benefit Period for this section are shown on page 3.

2.1 TOTAL DISABILITY BENEFIT. We will pay you the Monthly Benefit for a period of Total Disability that begins while this contract is in force.

The period for which benefits are payable:

1) Begins on the first day after the Elimination Period ends that you are Totally Disabled; and

2) Continues during your Total Disability but not beyond the end of the Benefit Period.

2.2 PARTIAL DISABILITY BENEFIT. We will pay you one-half of the Monthly Benefit for a period of Partial Disability that begins while this contract is in force.

The period for which benefits are payable:

1) Begins on the first day after the Elimination Period ends that you are Partially Disabled; and

2) Continues while you are Partially Disabled, but not beyond the earlier of:

   a) The date 6 months of benefits for Partial Disability have been paid; and

   b) The end of the Benefit Period.

For each Separate Period of Disability, benefits for Partial Disability will be paid for up to 6 months but not beyond the end of the Benefit Period.

3. PROVISIONS RELATING TO DISABILITY BENEFITS

3.1 PRESUMPTIVE TOTAL DISABILITY. You have a Presumptive Total Disability if your Injury or Sickness causes total and permanent loss of:

1) The ability to speak;

2) Hearing in both ears;

3) Sight in both eyes;

4) Use of both arms;

5) Use of both legs; or

6) Use of one arm and one leg,

If you have a Presumptive Total Disability we will:

1) Consider you to be Totally Disabled, waive the Elimination Period and pay monthly Disability benefits until the Benefit Period ends whether or not you:

   a) Are able to work,

   b) Engage in any Occupation; or

   c) Require Doctor's Care; and

2) Waive premiums until the Benefit Period ends.

Your Presumptive Total Disability ends when the Benefit Period ends.

3. PROVISIONS RELATING TO DISABILITY BENEFITS (continued)

3.2 CONCURRENT DISABILITIES. You will not be entitled to:

1) Benefits for more than one Disability during the same period of time; or

2) Concurrent Total and Partial Disability Benefits.

3.3 REHABILITATION. While you are Disabled, you may request reimbursement from us for participation in a rehabilitation program designed to help you return to work. The program and reimbursement amount must be agreed to in advance by you and us. Your monthly Disability benefits will not be affected by a rehabilitation program.

3.4 SUSPENSION OF COVERAGE WHILE IN MILITARY SERVICE. You may suspend coverage under your contract if:

1) You are in the military service of any nation or international authority or in a reserve component of the armed forces of the United States, including the National Guard;

2) You enter active duty or have it extended other than for training or for the purpose of determining physical fitness; and

3) Your period of active duty is expected to last at least three consecutive months.

In order to suspend coverage, we must receive your written request and proof that you are eligible for coverage suspension. We will suspend coverage from the later of the date you enter active duty and the date of receipt of your written request (or a later date, if requested) and will refund any unearned premium for the period of the suspension.

During coverage suspension, no coverage will be provided and no premiums must be paid.

Your coverage may be resumed as of the date of termination of active duty without evidence of insurability if:

1) Your active duty ends within five years from the date of suspension and before the Contract Anniversary on or after your 67th birthday; and

2) Within 90 days following the date active duty ends, you:

   a) Apply in writing to resume coverage; and

   b) Pay the pro-rata premium for coverage from the date of termination of active duty until the next premium due date.

The resumption of coverage shall be on the same basis as before the coverage suspension took effect and premiums will be the same as they would have been if coverage had not been suspended.

Disabilities from Sickness that first manifests itself and Injury that first occurs after the coverage is resumed are covered. However, disabilities that occur while coverage is suspended are not covered.

When calculating the expiration of the Elimination Period for a condition that did not arise during a period of active duty, the entire Elimination Period is the Elimination Period that would have applied before coverage suspension took effect. Only days before and after the period of suspension will be used to satisfy the Elimination Period.

If after five years from the date of suspension coverage has not resumed, the contract will be terminated. We will not give you prior notice of termination.

4. WAIVER OF PREMIUM BENEFIT

If Total Disability is continuous for 90 days we will:

1) Waive any premiums which come due while Total Disability continues, until the earliest of:

   a) The end of the Benefit Period;

   b) The date monthly Disability benefits end according to Sections 5.2 and 5.3; and

   c) The Contract Anniversary on or after your 67th birthday; and

2) Refund any premiums which came due and were paid during that 90 day period.

Premiums will be waived on the basis of the Interval of Payment in effect when Total Disability begins. As each premium is waived, this contract will continue in force until the next premium due date. On any premium due date, if premiums are no longer waived, you must pay them to keep this contract in force.

5. EXCLUSIONS AND LIMITATIONS

5.1 EXCLUSIONS. No benefits will be paid for:

1) Disability or any other loss resulting from any of the following:

   a) Pre-existing Conditions during the first 24 months after the Date of Issue, unless they are disclosed in the Application and not excluded from coverage by name or specific description.

   b) Normal pregnancy, child birth, or elective abortion. However, benefits will not be denied in the event of disability due to Complications of Pregnancy.

   c) Intentionally self-inflicted Injury.

   d) Attempted suicide.

   e) Any act of war, declared or undeclared, or any act incident to war.

   f) Any disease, disorder, activity or condition that was, as a result of the underwriting process, excluded in this contract by name or specific description.

   g) Commission of or attempt to commit a felony.

   h) Being engaged in an illegal Occupation.

   i) The suspension, revocation or surrender of your professional license to practice in your Occupation.

2) Any period during which you are legally incarcerated in a penal or correctional institution for more than seven days or during a period of legal detainment of more than seven days where the period of incarceration or legal detainment results in your inability to meet any work requirements contained in the definitions of Disability set forth in this contract.

3) Disability while you are residing outside of the United States, its territories and possessions.

5.2 LIMITATION FOR MENTAL / NERVOUS DISORDER, SUBSTANCE ABUSE / CHEMICAL DEPENDENCY. For Disability resulting from Mental / Nervous Disorders or Substance Abuse / Chemical Dependency, your monthly Disability benefits for all such Disabilities are limited during the life of this contract to a total of 24 monthly payments. However, this limitation will not apply:

1) While you are confined as an inpatient in a Hospital for treatment of a Mental / Nervous Disorder or Substance Abuse / Chemical Dependency; or

2) If your Mental / Nervous Disorder is a result of stroke, physical trauma or Alzheimer's Disease.

5. EXCLUSIONS AND LIMITATIONS (continued)

5.3 LIMITATION FOR SELF-REPORTED SYMPTOMS. For Disability resulting from a specific Injury or Sickness determined primarily from Self-Reported Symptoms, your monthly Disability benefits for all such Disabilities are limited during the life of the contract to a total of 24 monthly payments.

6. CLAIMS

6.1 NOTICE OF CLAIM. A notice of claim must be given to us at our Service Center within 20 days after any covered loss occurs or begins, or as soon after this as reasonably possible. Notice should include your name and contract number.

6.2 CLAIM FORMS. When we receive your notice of claim, we will send you any forms necessary for filing proof of loss. If we do not send this information within 15 days, you may meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in Section 6.3 Proofs of Loss.

6.3 PROOFS OF LOSS. Proof of loss must be given to us at our Service Center. This should be done within 90 days after termination of the period for which we are liable. Failure to give proof within 90 days will not affect the claim if proof is given as soon as is reasonably possible, but the proof must be given no later than one year from the time proof is otherwise required, unless you were legally incapacitated.

You must provide monthly proof of continuing Disability or at other intervals as we may require.

While you are Disabled, we may also:

1) Require satisfactory proof of your income before and during Disability. This proof may include, but is not limited to, copies of your W-2 form(s) and income tax returns.

2) Examine your financial records including, if you are Self-Employed, the financial records of your business entities. This will be done as often as is reasonably necessary during the Disability. At our expense, we or a financial examiner we choose will conduct such examinations. If you do not make a reasonable effort to submit to such examinations, we may not pay benefits.

6.4 TIMELY PAYMENT OF CLAIMS. We will pay benefits for losses covered under this contract when we receive sufficient proof of loss. Disability benefits due will be paid in arrears no less frequently than monthly. Payments will be made based on a 30-day month. Any disability benefit due for a period less than a full month will be based on the daily rate of one-thirtieth of the monthly benefit. When our liability ends, we will immediately pay any unpaid balance after we receive due proof of loss. If we pay a claim more than 30 days after we receive due proof of loss, the delayed payment will be increased by simple interest at the annual rate of 10%, beginning on the 31st day after we receive due proof of loss.

6.5 PAYMENT OF CLAIMS. Benefits will be paid to you, if living. Any benefits unpaid at your death will be paid to your estate. However, we may pay any benefit up to $1,000 to anyone related to you by blood or connected to you by marriage or domestic partnership whom we consider to be equitably entitled to the benefits. Any payment that we make in good faith under this provision shall fully discharge us to the extent of the payment. You may appeal any claim determination by contacting us in writing at our Service Center.

6.6 EXAMINATIONS. In addition to other proofs of loss, we may require you to be examined by a Doctor as often as reasonably necessary while a claim is pending or being paid. Examinations that we require under this provision will be at our expense.

6.7 LEGAL PROCEEDINGS. No legal proceeding to recover on this contract may be commenced until at least 60 days after written proof of loss has been given. No such proceeding may be commenced after 3 years (or if longer, the period of time specified in the laws and regulations of the state in which this contract was issued) from the time written proof of loss is required to be given.

7. PREMIUMS AND REINSTATEMENT

7.1 PREMIUM PAYMENTS. The Initial Premium and Interval of Payment are shown on page 3. The Initial Premium is due on or before the Date of Issue. Each subsequent premium is due and payable on the first day of its Interval of Payment. Premiums are payable at our Service Center. If you die while this contract is in force or discontinue coverage by your request, we will refund any unearned premium.

7.2 PREMIUM BILLING. We will send premium billings based on the Interval of Payment that you request. Except while premiums are being waived and subject to our published rules, you may change the Interval of Payment or method of billing by giving Notice.

7.3 PREMIUM IN DEFAULT AND GRACE PERIOD. Any premium not paid on or before the date it is due is a premium in default. Except for the Initial Premium, you may pay the premium in default within a grace period of 31 days after the date it is due. During the grace period, this contract will remain in force. If the premium in default is not paid within the grace period, this contract will terminate at the end of the grace period.

7.4 REINSTATEMENT. If this contract terminates at the end of the grace period for nonpayment of premiums, you may reinstate the contract within 6 months after the end of the grace period. To do this, any premiums in default must be paid. This contract is reinstated when we accept the payment, unless we also require a reinstatement application.

When an application is required, we must give you notice of approval or disapproval within 45 days after we receive the application. We will reinstate the contract as soon as the application is approved. If we do not notify you within the 45 day period, the contract will be automatically reinstated on the 45th day.

The reinstated contract will only cover a loss that results from:

1) Injury sustained on or after the date of reinstatement; or

2) Sickness that first manifests itself on or after the date of reinstatement.

Section 8.4 Time Limit for Certain Defenses will apply from the date this contract is reinstated with regard to statements made in the application for reinstatement, if any.

8. GENERAL PROVISIONS

8.1 ENTIRE CONTRACT. The Entire Contract consists of:

1) This contract including any attached riders, amendments or endorsements;

2) The Application attached to this contract; and

3) The Articles of Incorporation and Bylaws of the Society and all amendments to them. Benefits will not be reduced or eliminated by any future amendments to our Articles of Incorporation or Bylaws.

8.2 CHANGE OF CONTRACT. No change to this contract is valid unless it is made in writing and signed by our President or Secretary.

8.3 STATEMENTS IN THE APPLICATION. We will not use any statement to contest a claim or to have this contract declared invalid unless the statement is contained in the Application. All statements made in the Application are considered representations, not warranties.

8. GENERAL PROVISIONS (continued)

8.4 TIME LIMIT FOR CERTAIN DEFENSES.

1) **Misstatements in the Application.** After this contract has been in force during your lifetime for two years from the Date of Issue, no misstatements in the Application, except fraudulent misstatements, will be used to void this contract or to deny a claim for loss incurred or disability commencing after the expiration of the two-year period.

2) **Pre-existing Conditions.** No claim for a disability or other loss that begins more than two years after the Date of Issue will be reduced or denied because a disease or physical condition existed prior to the Date of Issue, unless excluded by name or specific description in this contract.

If you apply for an increase in insurance coverage under this contract, this provision will apply to the additional insurance from its effective date with regard to statements made in the application for the additional coverage.

8.5 MISSTATEMENT OF AGE OR SEX. If your age or sex has been misstated, any amount payable will be that which the premiums paid would have bought at the correct age and sex.

8.6 MAINTENANCE OF SOLVENCY. If the solvency of the Society becomes impaired, you may be required to make an extra payment. The Board of Directors will determine the amount of any extra payment. It will be based on each member's fair share of the deficiency.

8.7 MEMBERSHIP. You are a member of the Society. Rights and privileges of membership are set forth in the Articles of Incorporation and Bylaws of the Society. These rights and privileges are separate from ownership of this contract.

8.8 ASSIGNMENT. No assignment of this contract or any benefit payable under this contract will bind us unless we agree in writing prior to the date the assignment is signed. Unless otherwise specified by you, an assignment will take effect on the date the assignment is signed except for any payments made or actions taken by us prior to our receipt of the notice. We are not responsible for the validity or effect of any assignment. You will keep all membership rights and privileges.

8.9 DIVIDENDS. Each year we will determine our divisible surplus. This contract's share, if any, will be credited as a dividend.

8.10 CONDITIONALLY RENEWABLE TO AGE 75. Subject to the conditions below, you may keep this contract in force on a limited basis beyond the Contract Anniversary that is on or after your 67th birthday. Only the benefits in Section 2 Disability Benefits will continue. The Waiver of Premium Benefit will no longer apply and no riders may be continued. The following will apply:

1) The Benefit Period will be 12 months.

2) The Elimination Period will be the lesser of 90 days and the Elimination Period shown on page 3.

3) Premiums for each year of renewal will be based on your age and our rates in use at that time. We reserve the right to change premium rates by class.

On the Contract Anniversary on or after your 67th birthday and on each subsequent Contract Anniversary, you may renew this contract for one year if you meet the following conditions:

1) You have not been Disabled at any time since the last Contract Anniversary;

2) You are working at least 30 hours per week in a Gainful Occupation and have been for at least 10 out of the past 12 months;

3) The premium is paid on time; and

4) You have not reached your 75th birthday.

We may require proof that you have continued to work as required above.

8. GENERAL PROVISIONS (continued)

8.11 TERMINATION. This contract will terminate upon the earliest of the following dates:

1) The date of your death.

2) The date of your Notice to cancel this contract. The date of Notice is the date we receive it or, if later, the date you specify.

3) The date this contract terminates under Section 7.3 Premium in Default and Grace Period.

4) The later of the Contract Anniversary on or after your 67th birthday and the date beyond which you can no longer conditionally renew this contract (see Section 8.10).

8.12 EXTENSION OF BENEFITS. Coverage will be continued if you are Disabled when this contract terminates on any Contract Anniversary on or after your 67th birthday, provided you are within a Benefit Period and less than 12 months of benefits have been paid. Coverage will continue until the earliest of:

1) The date a new period of Disability begins;

2) The date the Benefit Period ends for this Disability;

3) The date monthly Disability benefits end according to Sections 5.2 and 5.3; and

4) The date 12 months of benefits have been paid.

Coverage continued under this section will be subject to all of the conditions and limitations of this contract.

8.13 CONFORMITY WITH STATE STATUTES. On the Date of Issue, any provision of this contract in conflict with the laws of the state in which you reside on that date, is amended to conform with those state laws.

Contract Number: 9999999999

THRIVENT
FINANCIAL®
Thrivent Financial for Lutherans
A Fraternal Benefit Society • Appleton, Wisconsin 54919-0001

Disability Income Insurance.
Noncancellable to age 67.
Conditionally renewable to age 75.
Pre-existing Condition limitations or exclusions and other limitations or exclusions may apply. Please read your contract carefully.
Annual dividends payable if earned.

THRIVENT FINANCIAL®

Thrivent Financial for Lutherans
A Fraternal Benefit Society • Appleton, Wisconsin 54919-0001

DISABILITY INCOME INSURANCE

This certificate of membership and disability income insurance is a legal contract between you and Thrivent Financial for Lutherans. We issue this contract based on the Application signed by the applicant and the payment of the initial premium shown on page 3. We will pay benefits according to the provisions of this contract. Coverage starts at 12:01 a.m. on the Date of Issue. It ends at 11:59 p.m. on the day this contract terminates.

This contract is guaranteed renewable to age 67. Premium rates for this contract are subject to change. You may keep this contract in force until the Contract Anniversary on or after your 67th birthday by paying premiums when due. We reserve the right to change premium rates by class.

Conditionally Renewable to age 75. You may keep this contract in force on a limited basis beyond the Contract Anniversary on or after your 67th birthday (see Section 8.10).

Right to Cancel. Please read this contract carefully. You may cancel this contract for any reason before midnight of the 30th day after you first receive it. Do this by returning this contract to us at our Service Center or to the representative through whom you bought it. Return of the contract by mail is effective on being postmarked, properly addressed and postage prepaid. If you cancel the contract, it will be deemed void from the beginning and the parties will be in the same position as if no contract had been issued. We will refund all premiums paid, including any policy fees or other charges.

Important Notice - Statements in the Application. Please read the copy of the Application attached to this contract. This contract was issued on the basis that all information shown in the Application is correct and complete. Omissions or misstatements in the Application could cause a claim to be denied or make this contract void. If any information shown is not correct or complete or if any past medical history has been left out of the Application or information about other disability income coverage has been misstated, contact us immediately.

Disability Income Insurance.
Guaranteed renewable to age 67.
Conditionally renewable to age 75.
Pre-existing Condition limitations or exclusions and other limitations or exclusions may apply. Please read your contract carefully.
Annual dividends payable if earned.

Service Center:
Thrivent Financial for Lutherans
4321 North Ballard Road
Appleton, WI 54919-0001

Telephone (800) 847-4836
www.thrivent.com

Signed for the Society

President Bradford L Hewitt

Secretary Teresa J Rasmussen

INSURED: JOHN DOE AGE: 35 SEX: MALE

CONTRACT NUMBER: H0012345 DATE OF ISSUE: JUNE 1, 2015

Contract Number: [9999999999]

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THRIVENT
FINANCIAL®
Thrivent Financial for Lutherans
4321 N. Ballard Road, Appleton, WI 54919-0001

Contract Schedule

	ANNUAL PREMIUM
BASIC BENEFIT	
DISABILITY INCOME INSURANCE	
PREMIUM FOR BASIC BENEFIT PAYABLE TO AGE 67	[$116.00]*
OCCUPATIONAL CLASS: [4A]	
TOBACCO STATUS: [NON-TOBACCO]	
PREMIUM RATING: [STANDARD]	
MONTHLY BENEFIT: [$1,000]	
ELIMINATION PERIOD: [3 MONTHS]	
BENEFIT PERIOD: [60 MONTHS]+	
ADDITIONAL BENEFITS	
DETAILS OF THE FOLLOWING ADDITIONAL BENEFIT RIDERS ARE GIVEN ON SEPARATE SCHEDULE PAGES:	
FORM ICC15 HR-IF-FPO	$37.84
FORM ICC15 HR-IO-SIO	$101.00
FORM ICC15 HR-IR-RDI	$34.40
FORM ICC15 HR-IU-SDI	$116.00
FORM ICC15 HR-IX-COL	$11.00
TOTAL ANNUAL PREMIUM	[$416.24]
INTERVAL OF PAYMENT	[ANNUAL]
INITIAL PREMIUM	[$416.24]

* RENEWAL OF COVERAGE BEYOND AGE 67 MAY REQUIRE AN INCREASE IN PREMIUM AFTER AGE 67. SEE SECTION 8.10 CONDITIONALLY RENEWABLE TO AGE 75.

+[BUT NOT BEYOND AGE 67. HOWEVER, IF YOU ARE DISABLED AT AGE 67 AND LESS THAN 12 MONTHS OF BENEFIT HAVE BEEN PAID, THE BENEFIT PERIOD WILL BE 12 MONTHS.] MONTHLY BENEFITS FOR MENTAL / NERVOUS DISORDERS, SUBSTANCE ABUSE / CHEMICAL DEPENDENCY AND SELF-REPORTED SYMPTOMS ARE LIMITED AS DESCRIBED IN SECTIONS 5.2 AND 5.3.

"AGE 67" MEANS THE CONTRACT ANNIVERSARY ON OR AFTER YOUR 67TH BIRTHDAY.

THIS CONTRACT IS ELIGIBLE FOR ANNUAL DIVIDENDS, BUT DIVIDENDS ARE NOT GUARENTEED. IT IS NOT EXPECTED THAT ANY DIVIDENDS WILL BE CREDITED.

THE INSURANCE DEPARTMENT OF THE STATE IN WHICH THIS CONTRACT WAS ISSUED MAY BE CONTACTED BY CALLING [(999) 999-9999].

INSURED: [JOHN DOE] AGE: [35] SEX: [MALE]

CONTRACT NUMBER: [H0012345] DATE OF ISSUE: [JUNE 1, 2015]

1. DEFINITIONS

Application. The application(s) and all application supplements and amendments to the Application.

Benefit Period. The maximum number of months for which we will pay benefits for any Separate Period of Disability. The Benefit Period begins at the end of the Elimination Period.

Complications of Pregnancy. Physical conditions considered distinct from pregnancy even though caused or aggravated by pregnancy, including non-elective Caesarean section, miscarriage, ectopic pregnancy, eclampsia, gestational diabetes, toxemia, and nephritis.

Complications of Pregnancy do not include morning sickness, false or pre-term labor, occasional spotting, rest prescribed by a Doctor, or similar conditions related to the management of a difficult pregnancy but not classified as Complications of Pregnancy.

Contract Anniversary. The same month and day of each year after issue as in the Date of Issue of this contract.

Contract Year. The first Contract Year is the period of time from the Date of Issue until the first Contract Anniversary. Thereafter, Contract Year is the period of time from one Contract Anniversary to the next Contract Anniversary.

Date of Issue. The Date of Issue of this contract as shown on page 3.

Disability. A Partial Disability or Total Disability.

Disabled. You have a Partial Disability or a Total Disability.

Doctor. A person legally licensed to practice medicine or psychology and acting within the scope of his or her license, or a health care practitioner who is legally licensed, and is acting within the scope of his or her license, to treat an Injury or Sickness causing Disability. When Disability is caused by a Mental/Nervous Disorder, Doctor means a licensed psychiatrist or a licensed doctoral-level psychologist.

Doctor may not include you, any person related to you by blood or marriage, any person who shares a significant business interest with you, or any person who is a partner in a legally sanctioned domestic partnership or civil union with you.

Doctor's Care. The regular and personal care of a Doctor that, under prevailing medical standards, is:

1) Appropriate for the Sickness or Injury causing the Disability; and

2) Intended to help you return to the material and substantial duties of your Regular Occupation or gainful employment in any Occupation.

Elimination Period. The number of days at the beginning of each Separate Period of Disability for which no monthly Disability benefits are payable. The Elimination Period starts on the first day you are Disabled. The number of days of Disability need not be consecutive, but must occur within a period of no more than two times the Elimination Period.

Gainful Occupation. An Occupation you perform for wage or profit.

Homemaker. Homemaker is an Occupation in which you perform regular household duties without remuneration, and are working fewer than 10 hours per week in a Gainful Occupation.

Hospital. An institution that is licensed as a Hospital by the proper authority of the state in which it is located. Hospital does not include:

1) Any institution, or part thereof, that is used primarily as a clinic, convalescent home, rest home, home for the aged, nursing home; or

2) Any facility primarily affording custodial, educational or rehabilitative care.

Injury. Bodily injury resulting from an accident, independent of all other causes, that occurs while this contract is in force. If Disability occurs more than 30 days after your injury, the condition will be considered a Sickness.

Insured. The person named as Insured on page 3.

1. DEFINITIONS (continued)

Mental / Nervous Disorder. A disorder that is classified as a mental or nervous disorder in the Diagnostic and Statistical Manual of Disorders (DSM) published by the American Psychiatric Association. We will use the DSM which is current at the time disability begins. If this manual is discontinued or replaced, we will use the appropriate manual in use by the American Psychiatric Association or its successor at the time disability begins.

Monthly Benefit. The monthly amount we will pay for a period of Total Disability. This amount is also used to calculate Partial Disability Benefits and Residual Disability Benefits, if any.

Notice. A request signed by you or provided in another manner acceptable to us and received in good order by us at our Service Center.

Occupation. A job, position or professional calling for which a person receives or could receive remuneration.

Partial Disability. A disability of the Insured:

1) That results from an Injury or Sickness;

2) That requires Doctor's Care for which we may periodically require a Doctor's report to support a claim of Disability; and

3) Due to which you are able to work in your Regular Occupation for at least 20%, but no more than 80%, of the time that you worked before your Sickness or Injury.

Partial Disability does not include the inability to work in your Regular Occupation due to:

1) Unemployment;

2) Loss of job; or

3) Job unsuitability not caused by Sickness or Injury.

Partially Disabled. You have a Partial Disability as defined above.

Pre-existing Condition. A condition for which:

1) Medical advice or treatment was recommended by a Doctor or received from a Doctor within the two-year period preceding the Date of Issue; or

2) Symptoms existed that would cause a person to seek diagnosis, care or treatment within the one-year period preceding the Date of Issue.

Regular Occupation. Regular Occupation is your Occupation at the time a Disability begins or another Occupation requiring similar skills or duties. If you are a Homemaker at the time Disability begins, that is your Regular Occupation. If the Occupational Class shown on page 3 is 1A or 2A, as of 2 years after the Disability began and while that period of Disability continues, Regular Occupation means any Occupation for which you are or you become reasonably suited by training, education, or experience.

Self-Employed. You are Self-Employed if you are the owner of a sole-proprietorship, a partner in a partnership, a member in a limited liability company, a shareholder in a closely held non-public corporation or a business owner in other legal business entities.

Self-Reported Symptoms. Symptoms of Sickness or Injury, which you report to your Doctor, that are not verifiable by objective medical means. Examples of Self-Reported Symptoms include (but are not limited to) headache, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness, and loss of energy.

1. DEFINITIONS (continued)

Separate Periods of Disability. Each Separate Period of Disability has both a new Elimination Period and a new Benefit Period. Periods of disability are separate if:

1) The later period of disability begins after a continuous period of 6 months for which no monthly Disability benefits are payable under this contract and:

   a) You work in a Gainful Occupation for at least 30 hours per week during that entire period; or

   b) If your Regular Occupation was not a Gainful Occupation when Disability began, you perform all of the substantial duties of that Regular Occupation during that entire period; or

2) The disability in a later period:

   a) Results from a cause that is unrelated to the cause or causes of the disability in a prior period; and

   b) Begins after you work in a Gainful Occupation for at least 30 hours per week for a continuous period of 30 days for which no monthly Disability benefits are payable under this contract.

Service Center. The Service Center address is shown on page 1.

Sickness. An illness or disease that first manifests itself while this contract is in force. Sickness includes:

1) Transplant of a part of your body to the body of another while this contract is in force; and

2) Complications of Pregnancy that first manifest themselves while your contract is in force. We will accept a Doctor's diagnosis of Complications of Pregnancy.

Substance Abuse / Chemical Dependency. The misuse of or dependence on any legal or illegal drug(s) or chemical(s), or controlled substance(s), including but not limited to alcohol, marijuana, cocaine, barbiturates, and narcotics. This definition does not apply to the use of medications that are taken as prescribed by a Doctor.

Total Disability. A disability of the Insured:

1) That results from an Injury or Sickness;

2) That requires Doctor's Care for which we may periodically require a Doctor's report to support a claim of Disability;

3) Due to which:

   a) You are unable to perform the material and substantial duties of your Regular Occupation; or

   b) You are able to work in your Regular Occupation but only for less than 20% of the time that you worked before your Sickness or Injury; and

4) During which you are not engaged in any Gainful Occupation other than in your Regular Occupation on a limited basis as described in 3(b) above.

Total Disability does not include the inability to perform duties due to:

1) Unemployment;

2) Loss of job; or

3) Job unsuitability not caused by Sickness or Injury.

Totally Disabled. You have a Total Disability.

we, our, us, Society. Thrivent Financial for Lutherans.

you, your and yours. The Insured named on page 3.

2. DISABILITY BENEFITS

The Monthly Benefit, Elimination Period and Benefit Period for this section are shown on page 3.

2.1 TOTAL DISABILITY BENEFIT. We will pay you the Monthly Benefit for a period of Total Disability that begins while this contract is in force.

The period for which benefits are payable:

1) Begins on the first day after the Elimination Period ends that you are Totally Disabled; and

2) Continues during your Total Disability but not beyond the end of the Benefit Period.

2.2 PARTIAL DISABILITY BENEFIT. We will pay you one-half of the Monthly Benefit for a period of Partial Disability that begins while this contract is in force.

The period for which benefits are payable:

1) Begins on the first day after the Elimination Period ends that you are Partially Disabled; and

2) Continues while you are Partially Disabled, but not beyond the earlier of:

   a) The date 6 months of benefits for Partial Disability have been paid; and

   b) The end of the Benefit Period.

For each Separate Period of Disability, benefits for Partial Disability will be paid for up to 6 months but not beyond the end of the Benefit Period.

3. PROVISIONS RELATING TO DISABILITY BENEFITS

3.1 PRESUMPTIVE TOTAL DISABILITY. You have a Presumptive Total Disability if your Injury or Sickness causes total and permanent loss of:

1) The ability to speak;

2) Hearing in both ears;

3) Sight in both eyes;

4) Use of both arms;

5) Use of both legs; or

6) Use of one arm and one leg,

If you have a Presumptive Total Disability we will:

1) Consider you to be Totally Disabled, waive the Elimination Period and pay monthly Disability benefits until the Benefit Period ends whether or not you:

   a) Are able to work,

   b) Engage in any Occupation; or

   c) Require Doctor's Care; and

2) Waive premiums until the Benefit Period ends.

Your Presumptive Total Disability ends when the Benefit Period ends.

3. PROVISIONS RELATING TO DISABILITY BENEFITS (continued)

3.2 CONCURRENT DISABILITIES. You will not be entitled to:

1) Benefits for more than one Disability during the same period of time; or

2) Concurrent Total and Partial Disability Benefits.

3.3 REHABILITATION. While you are Disabled, you may request reimbursement from us for participation in a rehabilitation program designed to help you return to work. The program and reimbursement amount must be agreed to in advance by you and us. Your monthly Disability benefits will not be affected by a rehabilitation program.

3.4 SUSPENSION OF COVERAGE WHILE IN MILITARY SERVICE. You may suspend coverage under your contract if:

1) You are in the military service of any nation or international authority or in a reserve component of the armed forces of the United States, including the National Guard;

2) You enter active duty or have it extended other than for training or for the purpose of determining physical fitness; and

3) Your period of active duty is expected to last at least three consecutive months.

In order to suspend coverage, we must receive your written request and proof that you are eligible for coverage suspension. We will suspend coverage from the later of the date you enter active duty and the date of receipt of your written request (or a later date, if requested) and will refund any unearned premium for the period of the suspension.

During coverage suspension, no coverage will be provided and no premiums must be paid.

Your coverage may be resumed as of the date of termination of active duty without evidence of insurability if:

1) Your active duty ends within five years from the date of suspension and before the Contract Anniversary on or after your 67th birthday; and

2) Within 90 days following the date active duty ends, you:

   a) Apply in writing to resume coverage; and

   b) Pay the pro-rata premium for coverage from the date of termination of active duty until the next premium due date.

The resumption of coverage shall be on the same basis as before the coverage suspension took effect and premiums will be the same as they would have been if coverage had not been suspended.

Disabilities from Sickness that first manifests itself and Injury that first occurs after the coverage is resumed are covered. However, disabilities that occur while coverage is suspended are not covered.

When calculating the expiration of the Elimination Period for a condition that did not arise during a period of active duty, the entire Elimination Period is the Elimination Period that would have applied before coverage suspension took effect. Only days before and after the period of suspension will be used to satisfy the Elimination Period.

If after five years from the date of suspension coverage has not resumed, the contract will be terminated. We will not give you prior notice of termination.

4. WAIVER OF PREMIUM BENEFIT

If Total Disability is continuous for 90 days we will:

1) Waive any premiums which come due while Total Disability continues, until the earliest of:

   a) The end of the Benefit Period;

   b) The date monthly Disability benefits end according to Sections 5.2 and 5.3; and

   c) The Contract Anniversary on or after your 67th birthday; and

2) Refund any premiums which came due and were paid during that 90 day period.

Premiums will be waived on the basis of the Interval of Payment in effect when Total Disability begins. As each premium is waived, this contract will continue in force until the next premium due date. On any premium due date, if premiums are no longer waived, you must pay them to keep this contract in force.

5. EXCLUSIONS AND LIMITATIONS

5.1 EXCLUSIONS. No benefits will be paid for:

1) Disability or any other loss resulting from any of the following:

   a) Pre-existing Conditions during the first 24 months after the Date of Issue, unless they are disclosed in the Application and not excluded from coverage by name or specific description.

   b) Normal pregnancy, child birth, or elective abortion. However, benefits will not be denied in the event of disability due to Complications of Pregnancy.

   c) Intentionally self-inflicted Injury.

   d) Attempted suicide.

   e) Any act of war, declared or undeclared, or any act incident to war.

   f) Any disease, disorder, activity or condition that was, as a result of the underwriting process, excluded in this contract by name or specific description.

   g) Commission of or attempt to commit a felony.

   h) Being engaged in an illegal Occupation.

   i) The suspension, revocation or surrender of your professional license to practice in your Occupation.

2) Any period during which you are legally incarcerated in a penal or correctional institution for more than seven days or during a period of legal detainment of more than seven days where the period of incarceration or legal detainment results in your inability to meet any work requirements contained in the definitions of Disability set forth in this contract.

3) Disability while you are residing outside of the United States, its territories and possessions.

5.2 LIMITATION FOR MENTAL / NERVOUS DISORDER, SUBSTANCE ABUSE / CHEMICAL DEPENDENCY. For Disability resulting from Mental / Nervous Disorders or Substance Abuse / Chemical Dependency, your monthly Disability benefits for all such Disabilities are limited during the life of this contract to a total of 24 monthly payments. However, this limitation will not apply:

1) While you are confined as an inpatient in a Hospital for treatment of a Mental / Nervous Disorder or Substance Abuse / Chemical Dependency; or

2) If your Mental / Nervous Disorder is a result of stroke, physical trauma or Alzheimer's Disease.

5. EXCLUSIONS AND LIMITATIONS (continued)

5.3 LIMITATION FOR SELF-REPORTED SYMPTOMS. For Disability resulting from a specific Injury or Sickness determined primarily from Self-Reported Symptoms, your monthly Disability benefits for all such Disabilities are limited during the life of the contract to a total of 24 monthly payments.

6. CLAIMS

6.1 NOTICE OF CLAIM. A notice of claim must be given to us at our Service Center within 20 days after any covered loss occurs or begins, or as soon after this as reasonably possible. Notice should include your name and contract number.

6.2 CLAIM FORMS. When we receive your notice of claim, we will send you any forms necessary for filing proof of loss. If we do not send this information within 15 days, you may meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in Section 6.3 Proofs of Loss.

6.3 PROOFS OF LOSS. Proof of loss must be given to us at our Service Center. This should be done within 90 days after termination of the period for which we are liable. Failure to give proof within 90 days will not affect the claim if proof is given as soon as is reasonably possible, but the proof must be given no later than one year from the time proof is otherwise required, unless you were legally incapacitated.

You must provide monthly proof of continuing Disability or at other intervals as we may require.

While you are Disabled, we may also:

1) Require satisfactory proof of your income before and during Disability. This proof may include, but is not limited to, copies of your W-2 form(s) and income tax returns.

2) Examine your financial records including, if you are Self-Employed, the financial records of your business entities. This will be done as often as is reasonably necessary during the Disability. At our expense, we or a financial examiner we choose will conduct such examinations. If you do not make a reasonable effort to submit to such examinations, we may not pay benefits.

6.4 TIMELY PAYMENT OF CLAIMS. We will pay benefits for losses covered under this contract when we receive sufficient proof of loss. Disability benefits due will be paid in arrears no less frequently than monthly. Payments will be made based on a 30-day month. Any disability benefit due for a period less than a full month will be based on the daily rate of one-thirtieth of the monthly benefit. When our liability ends, we will immediately pay any unpaid balance after we receive due proof of loss. If we pay a claim more than 30 days after we receive due proof of loss, the delayed payment will be increased by simple interest at the annual rate of 10%, beginning on the 31st day after we receive due proof of loss.

6.5 PAYMENT OF CLAIMS. Benefits will be paid to you, if living. Any benefits unpaid at your death will be paid to your estate. However, we may pay any benefit up to $1,000 to anyone related to you by blood or connected to you by marriage or domestic partnership whom we consider to be equitably entitled to the benefits. Any payment that we make in good faith under this provision shall fully discharge us to the extent of the payment. You may appeal any claim determination by contacting us in writing at our Service Center.

6.6 EXAMINATIONS. In addition to other proofs of loss, we may require you to be examined by a Doctor as often as reasonably necessary while a claim is pending or being paid. Examinations that we require under this provision will be at our expense.

6.7 LEGAL PROCEEDINGS. No legal proceeding to recover on this contract may be commenced until at least 60 days after written proof of loss has been given. No such proceeding may be commenced after 3 years (or if longer, the period of time specified in the laws and regulations of the state in which this contract was issued) from the time written proof of loss is required to be given.

7. PREMIUMS AND REINSTATEMENT

7.1 PREMIUM PAYMENTS. The Initial Premium and Interval of Payment are shown on page 3. The Initial Premium is due on or before the Date of Issue. Each subsequent premium is due and payable on the first day of its Interval of Payment. Premiums are payable at our Service Center. If you die while this contract is in force or discontinue coverage by your request, we will refund any unearned premium.

7.2 PREMIUM BILLING. We will send premium billings based on the Interval of Payment that you request. Except while premiums are being waived and subject to our published rules, you may change the Interval of Payment or method of billing by giving Notice.

7.3 PREMIUM IN DEFAULT AND GRACE PERIOD. Any premium not paid on or before the date it is due is a premium in default. Except for the Initial Premium, you may pay the premium in default within a grace period of 31 days after the date it is due. During the grace period, this contract will remain in force. If the premium in default is not paid within the grace period, this contract will terminate at the end of the grace period.

7.4 REINSTATEMENT. If this contract terminates at the end of the grace period for nonpayment of premiums, you may reinstate the contract within 6 months after the end of the grace period. To do this, any premiums in default must be paid. This contract is reinstated when we accept the payment, unless we also require a reinstatement application.

When an application is required, we must give you notice of approval or disapproval within 45 days after we receive the application. We will reinstate the contract as soon as the application is approved. If we do not notify you within the 45 day period, the contract will be automatically reinstated on the 45th day.

The reinstated contract will only cover a loss that results from:

1) Injury sustained on or after the date of reinstatement; or

2) Sickness that first manifests itself on or after the date of reinstatement.

Section 8.4 Time Limit for Certain Defenses will apply from the date this contract is reinstated with regard to statements made in the application for reinstatement, if any.

8. GENERAL PROVISIONS

8.1 ENTIRE CONTRACT. The Entire Contract consists of:

1) This contract including any attached riders, amendments or endorsements;

2) The Application attached to this contract; and

3) The Articles of Incorporation and Bylaws of the Society and all amendments to them. Benefits will not be reduced or eliminated by any future amendments to our Articles of Incorporation or Bylaws.

8.2 CHANGE OF CONTRACT. No change to this contract is valid unless it is made in writing and signed by our President or Secretary.

8.3 STATEMENTS IN THE APPLICATION. We will not use any statement to contest a claim or to have this contract declared invalid unless the statement is contained in the Application. All statements made in the Application are considered representations, not warranties.

8. GENERAL PROVISIONS (continued)

8.4 TIME LIMIT FOR CERTAIN DEFENSES.

1) **Misstatements in the Application.** After this contract has been in force during your lifetime for two years from the Date of Issue, no misstatements in the Application, except fraudulent misstatements, will be used to void this contract or to deny a claim for loss incurred or disability commencing after the expiration of the two-year period.

2) **Pre-existing Conditions.** No claim for a disability or other loss that begins more than two years after the Date of Issue will be reduced or denied because a disease or physical condition existed prior to the Date of Issue, unless excluded by name or specific description in this contract.

If you apply for an increase in insurance coverage under this contract, this provision will apply to the additional insurance from its effective date with regard to statements made in the application for the additional coverage.

8.5 MISSTATEMENT OF AGE OR SEX. If your age or sex has been misstated, any amount payable will be that which the premiums paid would have bought at the correct age and sex.

8.6 MAINTENANCE OF SOLVENCY. If the solvency of the Society becomes impaired, you may be required to make an extra payment. The Board of Directors will determine the amount of any extra payment. It will be based on each member's fair share of the deficiency.

8.7 MEMBERSHIP. You are a member of the Society. Rights and privileges of membership are set forth in the Articles of Incorporation and Bylaws of the Society. These rights and privileges are separate from ownership of this contract.

8.8 ASSIGNMENT. No assignment of this contract or any benefit payable under this contract will bind us unless we agree in writing prior to the date the assignment is signed. Unless otherwise specified by you, an assignment will take effect on the date the assignment is signed except for any payments made or actions taken by us prior to our receipt of the notice. We are not responsible for the validity or effect of any assignment. You will keep all membership rights and privileges.

8.9 DIVIDENDS. Each year we will determine our divisible surplus. This contract's share, if any, will be credited as a dividend. Since we do not expect this contract to contribute to divisible surplus, it is not expected that any dividends will be credited.

8.10 CONDITIONALLY RENEWABLE TO AGE 75. Subject to the conditions below, you may keep this contract in force on a limited basis beyond the Contract Anniversary that is on or after your 67th birthday. Only the benefits in Section 2 Disability Benefits will continue. The Waiver of Premium Benefit will no longer apply and no riders may be continued. The following will apply:

1) The Benefit Period will be 12 months.

2) The Elimination Period will be the lesser of 90 days and the Elimination Period shown on page 3.

3) Premiums for each year of renewal will be based on your age and our rates in use at that time. We reserve the right to change premium rates by class.

On the Contract Anniversary on or after your 67th birthday and on each subsequent Contract Anniversary, you may renew this contract for one year if you meet the following conditions:

1) You have not been Disabled at any time since the last Contract Anniversary;

2) You are working at least 30 hours per week in a Gainful Occupation and have been for at least 10 out of the past 12 months;

3) The premium is paid on time; and

4) You have not reached your 75th birthday.

We may require proof that you have continued to work as required above.

8. GENERAL PROVISIONS (continued)

8.11 TERMINATION. This contract will terminate upon the earliest of the following dates:

1) The date of your death.

2) The date of your Notice to cancel this contract. The date of Notice is the date we receive it or, if later, the date you specify.

3) The date this contract terminates under Section 7.3 Premium in Default and Grace Period.

4) The later of the Contract Anniversary on or after your 67th birthday and the date beyond which you can no longer conditionally renew this contract (see Section 8.10).

8.12 EXTENSION OF BENEFITS. Coverage will be continued if you are Disabled when this contract terminates on any Contract Anniversary on or after your 67th birthday, provided you are within a Benefit Period and less than 12 months of benefits have been paid. Coverage will continue until the earliest of:

1) The date a new period of Disability begins;

2) The date the Benefit Period ends for this Disability;

3) The date monthly Disability benefits end according to Sections 5.2 and 5.3; and

4) The date 12 months of benefits have been paid.

Coverage continued under this section will be subject to all of the conditions and limitations of this contract.

8.13 CONFORMITY WITH STATE STATUTES. On the Date of Issue, any provision of this contract in conflict with the laws of the state in which you reside on that date, is amended to conform with those state laws.

THRIVENT
FINANCIAL®
Thrivent Financial for Lutherans
A Fraternal Benefit Society • Appleton, Wisconsin 54919-0001

DISABILITY INCOME INSURANCE

Disability Income Insurance.
Guaranteed renewable to age 67.
Conditionally renewable to age 75.
Pre-existing Condition limitations or exclusions and other limitations or exclusions may apply. Please read your contract carefully.
Annual dividends payable if earned.

THRIVENT FINANCIAL®
Thrivent Financial for Lutherans

RIDER

Contract Number: 9999999999

FUTURE PURCHASE OPTION BENEFIT

Date of Issue of this Rider: JUNE 1, 2015

We include this rider as part of this contract based on the Application signed by the applicant and the payment of premiums as shown on page 3-FPO. If any provisions of this rider are in conflict with the terms of the contract, the provisions of this rider will control.

1. DEFINITIONS.

Date of Issue of this Rider. Unless otherwise shown above or on page 3-FPO, the Date of Issue of this Rider is the Date of Issue of this contract.

Purchase Option Dates.

Fixed Purchase Option Dates. Fixed Purchase Option Dates occur every third Contract Anniversary measured from the Date of Issue of this contract. The last option date will occur on the earlier of:

1) The 15th Contract Anniversary; and

2) The Contract Anniversary on or next following your 55th birthday.

Additional Purchase Option Dates. If you have group long-term disability insurance coverage that terminates while this rider is in force, an Additional Purchase Option Date occurs on the date that coverage ends. Only one such additional option may be exercised in a Contract Year.

Total Purchase Option Limit. The Total Purchase Option Limit is shown on page 3-FPO. It is the maximum cumulative amount of additional insurance that may be purchased under this rider.

2. THE BENEFIT. An option to buy additional disability income insurance will become effective on each Fixed Purchase Option Date and each Additional Purchase Option Date. Options to purchase are subject to the Conditions of Purchase.

3. CONDITIONS OF PURCHASE. On each Purchase Option Date, you may buy additional disability income insurance coverage without evidence of insurability as to your health. The additional insurance will be added to this contract unless we require it to be issued on a separate contract form that we offer at the time of purchase that is most like this contract. Each purchase is subject to the following conditions:

1) You must submit an application within 31 days after the Purchase Option Date and pay the required premium.

2) The sum of all additional insurance purchased under this rider may not exceed the Total Purchase Option Limit.

3) Each additional purchase under this provision must be a multiple of $100.

4) You must qualify for the additional insurance under our financial underwriting rules and issue and participation limits then in use. Upon request, we will furnish these limits to you.

5) If the additional insurance is:

   a) Added to an existing coverage on this contract, it will have the same Elimination Period and Benefit Period as for the benefit you are increasing.

   b) Issued as a separate contract or as a new rider on this contract, then:

      i) The Benefit Period may not be longer than the Benefit Period shown on page 3 of this contract; and

      ii) The Elimination Period may not be shorter than the Elimination Period shown on page 3 of this contract.

(continued)

Contract Number: 9999999999

FUTURE PURCHASE OPTION BENEFITT **(continued)**

6) The additional insurance will be effective on the Purchase Option Date.

7) The premium for the additional insurance will be based on:

   a) Your sex and attained age;

   b) The plan and amount of insurance purchased;

   c) The Occupational Class, Tobacco Status and Premium Rating shown on page 3 of this contract; and

   d) The premium rates in effect on the effective date of the purchase.

8) If any exclusion rider applies to this contract, the additional insurance will have such an exclusion rider.

9) Paragraph (1), Misstatements in the Application, of the Time Limit for Certain Defenses provision of this contract will apply to the additional insurance from its effective date with regard to statements made in the application for the additional coverage.

10) If this contract includes a Cost of Living Indexing Benefit rider or a Residual Disability Benefit rider, the included rider(s):

   a) Must apply to the additional insurance if the insurance is provided under this contract; or

   b) Will apply to the additional insurance if the insurance is provided under a new contract and these or similar rider forms are then offered by us and purchased by you.

   An additional premium is payable for the increased rider coverage(s).

4. OPTIONS EXERCISED WHILE DISABLED. An option to buy additional insurance may be exercised even if you are Disabled. Waiver of premium benefits will apply to the additional insurance even if a Disability that qualifies for waiver of premium benefits begins before the effective date of the additional insurance. Premiums are waived as soon as they are waived under this contract. Except for the waiver of premium benefit, the additional insurance only covers a Disability which begins after the effective date of the additional insurance as a Separate Period of Disability under this contract.

5. TERMINATION. This rider will terminate upon the earliest of the following dates:

1) The date 31 days after the Contract Anniversary on or after your 55th birthday.

2) The date 31 days after the 15th Contract Anniversary.

3) The date the cumulative amount of additional insurance purchased under this rider equals the Total Purchase Option Limit.

4) The date you give Notice to cancel this rider.

5) The date this contract terminates.

Signed for Thrivent Financial for Lutherans

President Bradford L Hewitt

Secretary Teresa J Rasmussen

FUTURE PURCHASE OPTION BENEFIT

FORM HR-IF-FPO (15)

INSURED: [JOHN DOE]
AGE: [35] SEX: [MALE]

TOTAL PURCHASE OPTION LIMIT: [$3,000]

ANNUAL PREMIUM: [$41.62]

PREMIUMS ARE PAYABLE TO [06/01/2030]. PREMIUMS MAY CHANGE IF OTHER BENEFITS OR RIDERS INCLUDED WITH THIS CONTRACT ARE CHANGED.

THRIVENT FINANCIAL®
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RIDER

Contract Number: [9999999999]

COST OF LIVING INDEXING BENEFIT

Date of Issue of this Rider: [JUNE 1, 2015]

We include this rider as part of this contract based on the Application signed by the applicant and the payment of premiums as shown on page 3-COL. If any provisions of this rider are in conflict with the terms of the contract, the provisions of this rider will control.

1. DEFINITIONS.

Cost of Living Index. The Cost of Living Index is the Consumer Price Index for All Urban Consumers for the third calendar month prior to the date on which adjustments are made under Section 2 of this rider. This index is published by the U.S. Bureau of Labor Statistics. If this index is changed or discontinued, we will use a similar index upon approval by the Interstate Insurance Product Regulation Commission. We will notify you of any change in the index before we use it.

Date of Issue of this Rider. Unless otherwise shown above or on page 3-COL, the Date of Issue of this Rider is the Date of Issue of this contract.

2. THE BENEFIT. For benefits that have Benefit Periods of 60 months or longer, this rider adjusts:

1) The Monthly Benefit for the base contract and the Supplemental Disability Income Benefit rider if any; and

2) The Maximum Monthly Benefit on the Social Insurance Offset Benefit rider, if any.

The first adjustment will occur on the first anniversary of the start of Disability. Additional adjustments will occur on each subsequent anniversary while Disability continues and this rider is in force. The adjusted benefit is:

1) The Monthly Benefit or Maximum Monthly Benefit, as applicable; multiplied by

2) The Cost of Living Index at the most recent anniversary of the start of Disability; divided by

3) The Cost of Living Index at the start of Disability.

However, the adjusted Monthly Benefit(s) and Maximum Monthly Benefit will not exceed the smaller of:

1) The corresponding Monthly Benefit(s) or Maximum Monthly Benefit increased by 6% compounded annually from the start of Disability; and

2) Two times the corresponding Monthly Benefit(s) or Maximum Monthly Benefit at the start of Disability.

No adjustments will be made on an anniversary of the first day of Disability if the Cost of Living Index stays the same as or decreases from the index on the previous anniversary.

Adjustments apply during a Separate Period of Disability that begins while this rider is in force. At the beginning of each Separate Period of Disability, each applicable Monthly Benefit and Maximum Monthly Benefit will be that benefit unadjusted for any previous changes in the Cost of Living Index.

3. IMPACT ON RESIDUAL DISABILITY INCOME BENEFIT RIDER. If this contract has a Residual Disability Income Benefit rider, for benefits that have Benefit Periods of 60 months or longer, Prior Earnings will be adjusted using the same rules as used when adjusting the Monthly Benefit in this rider.

COST OF LIVING INDEXING BENEFIT **(continued)**

4. POST-DISABILITY PURCHASE OPTION. When you return to full-time work for 6 consecutive months after the end of a period of Disability during which benefits were temporarily increased according to Section 2 of this rider, you may elect to buy increased benefits. You may increase the Monthly Benefit(s) and the Maximum Monthly Benefit on each of these benefits up to the adjusted amounts used in computing your final payment from each benefit, as applicable, during the prior period of Disability. The additional disability income insurance will be added to this contract, unless we require it to be issued on a separate contract form that we offer at the time of purchase that is most like this contract.

The purchase of additional insurance is subject to the following conditions:

1) You must submit an application within 31 days after the date you have returned to full-time work for 6 consecutive months, and pay the required premium.

2) Application must be made while this rider is in force and before your 60th birthday.

3) Each increase under this provision must be a multiple of $100. If the increase is not a multiple of $100, the increase will be rounded up to the next $100 increment.

4) You must qualify for the additional insurance under our financial underwriting rules and issue and participation limits then in use. Upon request, we will furnish these limits to you.

5) The additional insurance will have the same Elimination Period and Benefit Period as for the benefit you are increasing.

6) The additional insurance will be effective on the date you complete the application requirements and pay us the first premium.

7) The premium for the additional insurance will be based on:

   a) Your sex and attained age;

   b) The plan and amount of additional insurance purchased;

   c) The Occupational Class, Tobacco Status and Premium Rating shown on page 3 of this contract; and

   d) The premium rates in effect on the effective date of the purchase.

8) If any exclusion rider applies to this contract, the additional insurance will have such an exclusion rider.

9) Paragraph (1), Misstatements in the Application, of the Time Limit for Certain Defenses provision of this contract will apply to the additional insurance from its effective date with regard to statements made in the application for the additional coverage.

10) This Cost of Living Indexing Benefit rider and any Residual Disability Benefit rider attached to this contract:

   a) Must apply to the additional insurance if the insurance is provided under this contract; or

   b) Will apply to the additional insurance if the insurance is provided under a new contract and these or similar rider forms are then offered by us and purchased by you.

An additional premium is payable for the rider coverage(s).

COST OF LIVING INDEXING BENEFIT **(continued)**

5. TIME LIMIT FOR CERTAIN DEFENSES FOR THIS RIDER. The Time Limit for Certain Defenses provision of this contract applies to this rider and its Application from the Date of Issue of this Rider.

6. TERMINATION. This rider will terminate on the earliest of the following dates:

1) The Contract Anniversary on or after your 67th birthday.

2) The date you give Notice to cancel this rider.

3) The date this contract terminates.

Signed for Thrivent Financial for Lutherans

President Bradford L Hewitt

Secretary Teresa J Rasmussen

COST OF LIVING INDEXING BENEFIT

FORM HR-IX-COL (15)

INSURED: [JOHN DOE]
AGE: [35] SEX: [MALE]

ANNUAL PREMIUM: [$12.10]

PREMIUMS ARE PAYABLE TO THE CONTRACT ANNIVERSARY ON OR AFTER YOUR 67TH BIRTHDAY. PREMIUMS MAY CHANGE IF OTHER BENEFITS OR RIDERS INCLUDED WITH THIS CONTRACT ARE CHANGED.

SOCIAL INSURANCE OFFSET BENEFIT

Date of Issue of this Rider: JUNE 1, 2015

We include this rider as part of this contract based on the Application signed by the applicant and the payment of premiums as shown on page 3-SIO. If any provisions of this rider are in conflict with the terms of the contract, the provisions of this rider will control. The Maximum Monthly Benefit, Elimination Period and Benefit Period for this rider are shown on page 3-SIO.

1. DEFINITIONS.

Date of Issue of this Rider. Unless otherwise shown above or on page 3-SIO, the Date of Issue of this Rider is the Date of Issue of this contract.

Monthly Benefit. For each month that benefits for Disability are payable, the Monthly Benefit for this rider is:

1) The Maximum Monthly Benefit shown on page 3-SIO; less

2) Any Social Insurance Benefits payable for that month.

Social Insurance Offset Benefits will not be reduced during a Benefit Period due to any legislated automatic increase in Social Insurance Benefits during that Benefit Period. Neither payments under this rider nor Social Insurance Benefits received by you will reduce other monthly Disability benefits payable under this contract. For any month, if Social Insurance Benefits equal or exceed the Maximum Monthly Benefit, the Monthly Benefit will be zero.

Social Insurance Benefits. Disability benefits payable under:

1) The Social Security disability program mandated by the U.S. Social Security Act;

2) Any workers' compensation or occupational disease act or law of any government;

3) The Railroad Retirement Act;

4) Any Civil Service or federal employee programs; or

5) The U.S. Department of Veterans Affairs disability compensation program.

2. SOCIAL INSURANCE OFFSET BENEFITS.

2.1 TOTAL DISABILITY BENEFIT. We will pay you the Monthly Benefit for a period of Total Disability that begins while this rider is in force.

The period for which benefits are payable:

1) Begins on the first day after the Elimination Period ends that you are Totally Disabled; and

2) Continues during your Total Disability but not beyond the end of the Benefit Period.

Payment of benefits is subject to Section 3 Filing for Social Insurance Benefits.

2.2 PARTIAL DISABILITY BENEFIT. We will pay you one-half of the Monthly Benefit for a period of Partial Disability that begins while this rider is in force.

The period for which benefits are payable:

1) Begins on the first day after the Elimination Period ends that you are Partially Disabled; and

2) Continues while you are Partially Disabled, but not beyond the earlier of:

   a) The date 6 months of benefits for Partial Disability have been paid; and

   b) The end of the Benefit Period.

For each Separate Period of Disability, benefits for Partial Disability will be paid for up to 6 months but not beyond the end of the Benefit Period. Payment of benefits is subject to Section 3 Filing for Social Insurance Benefits.

Contract Number: 9999999999

SOCIAL INSURANCE OFFSET BENEFITT **(continued)**

3. FILING FOR SOCIAL INSURANCE BENEFITS. No benefits will be paid under this rider unless you give us written proof:

1) That you have made a timely and complete application for Social Insurance Benefits for Disability for which you may be eligible.

2) Of the amount of Social Insurance Benefits payable to you and the date payment began.

3) That you have not waived your rights to Social Insurance Benefits.

4) That if Social Insurance Benefits have been denied, you have appealed the denial and any subsequent denial, as we may request.

You also must:

1) Provide written authorization for us to obtain information from the provider of a Social Insurance Benefit about the status of your application and claim for Social Insurance Benefits; and

2) Notify us of any change in your eligibility for, entitlement to, or receipt of Social Insurance Benefits. Such notice must be furnished within 30 days of the change in status.

These requirements are in addition to the Claims provisions of this contract.

4. LUMP SUM SOCIAL INSURANCE BENEFITS. A social insurance program may pay you a lump sum instead of future monthly payments. If that happens, for the purpose of determining the benefit paid under this rider, we will determine how many monthly payments the lump sum covers by dividing:

1) The lump sum excluding any portion that is a retroactive payment; by

2) The Maximum Monthly Benefit shown on page 3-SIO.

Payments under this rider will be suspended for the same number of months computed above. Any fraction of a month will be based on a 30-day month.

5. LIMITED RIGHT TO INCREASE PREMIUMS. We have the right to increase premiums on this rider if:

1) Benefits are restricted or rules for qualification are changed in any program that provides Social Insurance Benefits; or

2) One or more of the programs that provide Social Insurance Benefits is terminated.

The increased premium will not be greater than the premium would have been for the corresponding Basic Benefit issued on the same date as this rider.

6. TIME LIMIT FOR CERTAIN DEFENSES FOR THIS RIDER. The Time Limit for Certain Defenses provision of this contract applies to this rider and its Application from the Date of Issue of this Rider.

7. TERMINATION. This rider will terminate upon the earliest of the following dates:

1) The Contract Anniversary on or after your 67th birthday.

2) The date you first receive Social Security retirement benefits.

3) The date you give Notice to cancel this rider.

4) The date this contract terminates.

Signed for Thrivent Financial for Lutherans

President Bradford L Hewitt

Secretary Teresa J Rasmussen

SOCIAL INSURANCE OFFSET BENEFIT

FORM HR-IO-SIO (15)

INSURED: [JOHN DOE]
AGE: [35] SEX: [MALE]

MAXIMUM MONTHLY BENEFIT: [$1,000]*
ELIMINATION PERIOD: [3]MONTHS
BENEFIT PERIOD: [60 MONTHS]+

* USED TO DETERMINE THE MONTHLY BENEFIT AS DEFINED IN SECTION 1 OF FORM HR-IO-SIO (15)

+ BUT NOT BEYOND AGE 67. HOWEVER, IF YOU ARE DISABLED AT AGE 67 AND LESS THAN 12 MONTHS OF BENEFIT HAVE BEEN PAID, THE BENEFIT PERIOD WILL BE 12 MONTHS. MONTHLY BENEFITS FOR MENTAL / NERVOUS DISORDERS, SUBSTANCE ABUSE / CHEMICAL DEPENDENCY AND SELF-REPORTED SYMPTOMS ARE LIMITED AS DESCRIBED IN SECTIONS 5.2 AND 5.3 OF THIS CONTRACT.

"AGE 67" MEANS THE CONTRACT ANNIVERSARY ON OR AFTER YOUR 67TH BIRTHDAY.

ANNUAL PREMIUM PAYABLE TO AGE 67: [$111.10]

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Thrivent Financial for Lutherans

RIDER

Contract Number: 9999999999

SUPPLEMENTAL DISABILITY INCOME BENEFIT

Date of Issue of this Rider: JUNE 1, 2015

We include this rider as part of this contract based on the Application signed by the applicant and the payment of premiums as shown on page 3-SIB. If any provisions of this rider are in conflict with the terms of the contract, the provisions of this rider will control. The Monthly Benefit, Elimination Period and Benefit Period for this rider are shown on page 3-SIB.

1. DATE OF ISSUE OF THIS RIDER. Unless otherwise shown above or on page 3-SIB, the Date of Issue of this Rider is the Date of Issue of this Contract.

2. TOTAL DISABILITY BENEFIT. We will pay you the Monthly Benefit for a period of Total Disability that begins while this rider is in force.

The period for which benefits are payable:

1) Begins on the first day after the Elimination Period ends that you are Totally Disabled; and

2) Continues during your Total Disability but not beyond the end of the Benefit Period.

3. PARTIAL DISABILITY BENEFIT. We will pay you one-half of the Monthly Benefit for a period of Partial Disability that begins while this rider is in force.

The period for which benefits are payable:

1) Begins on the first day after the Elimination Period ends that you are Partially Disabled; and

2) Continues while you are Partially Disabled, but not beyond the earlier of:

   a) The date 6 months of benefits for Partial Disability have been paid; and

   b) The end of the Benefit Period.

For each Separate Period of Disability, benefits for Partial Disability will be paid for up to 6 months but not beyond the end of the Benefit Period.

4. TIME LIMIT FOR CERTAIN DEFENSES FOR THIS RIDER. The Time Limit for Certain Defenses provision of this contract applies to this rider and its Application from the Date of Issue of this Rider.

5. TERMINATION. This rider will terminate upon the earliest of the following dates:

1) The Contract Anniversary on or after your 67th birthday.

2) The date you give Notice to cancel this rider.

3) The date this contract terminates.

Signed for Thrivent Financial for Lutherans

President Bradford L Hewitt

Secretary Teresa J Rasmussen

SUPPLEMENTAL DISABILITY INCOME BENEFIT

FORM HR-IU-SDI (15)

INSURED: [JOHN DOE]
AGE: [35] SEX: [MALE]

MONTHLY BENEFIT: [$1,000]
ELIMINATION PERIOD: [3]MONTHS
BENEFIT PERIOD: [60 MONTHS]+

+[BUT NOT BEYOND AGE 67. HOWEVER, IF YOU ARE DISABLED AT AGE 67 AND LESS THAN 12 MONTHS OF BENEFIT HAVE BEEN PAID, THE BENEFIT PERIOD WILL BE 12 MONTHS.] MONTHLY BENEFITS FOR MENTAL / NERVOUS DISORDERS, SUBSTANCE ABUSE / CHEMICAL DEPENDENCY AND SELF-REPORTED SYMPTOMS ARE LIMITED AS DESCRIBED IN SECTIONS 5.2 AND 5.3.

"AGE 67" MEANS THE CONTRACT ANNIVERSARY ON OR AFTER YOUR 67TH BIRTHDAY.

ANNUAL PREMIUM PAYABLE TO AGE 67: [$127.60]

RESIDUAL DISABILITY BENEFIT

Date of Issue of this Rider: JUNE 1, 2015

We include this rider as part of this contract based on the Application signed by the applicant and the payment of premiums as shown on page 3-RDI. If any provisions of this rider are in conflict with the terms of the contract, the provisions of this rider will control.

1. DEFINITIONS.

Cost of Living Index. The Cost of Living Index is the Consumer Price Index for All Urban Consumers for the third calendar month prior to the date on which adjusting is done (see Prior Earnings). This index is published by the U.S. Bureau of Labor Statistics. If this index is changed or discontinued, we will use a similar index upon approval by the Interstate Insurance Product Regulation Commission. We will notify you of any change in the index before we use it.

Date of Issue of this Rider. Unless otherwise shown above or on page 3-RDI, the Date of Issue of this Rider is the Date of Issue of this contract.

Disability. This contract's definition of Disability is amended to be "A Partial Disability, Residual Disability or Total Disability."

Disabled. This contract's definition of Disabled is amended to be "You have a Partial Disability, a Residual Disability or a Total Disability."

Earnings. Earnings is the sum of your earnings as an Employee and as a Self-Employed person.

If you are an Employee, Earnings includes salary, wages, commissions, bonuses, fees, and income earned for services performed, before taxes, as reported for federal income tax purposes.

If you are Self-Employed, Earnings includes salary, wages, commissions, bonuses, your share of Net Profit and contributions to a pension or profit sharing plan made by the business on your behalf. The amounts included are before taxes and as reported for federal income tax purposes.

Whether you are an Employee or Self-Employed, Earnings does not include benefits received from:

1) Deferred compensation;
2) Individual and group disability income plans;
3) Formal sick pay plans;
4) Retirement plans;
5) Royalties; or
6) Passive investments.

Employee. An Employee is an individual who:

1) Works for an employer for Earnings on a regular basis; and
2) As a result of that work, receives a W-2 or 1099 tax form.

Loss of Earnings. Loss of Earnings for each month while you are Disabled is Prior Earnings less your Earnings for that month.

Net Profit. Net Profit is the total amount of revenue from the sale of goods and services due to the ordinary and ongoing operation of all businesses that you own, after deductions for business expenses, as reported for federal income tax purposes.

Partial Disability. This contract's definition of Partial Disability is amended to include Residual Disability.

RESIDUAL DISABILITY BENEFIT **(continued)**

Prior Earnings. Prior Earnings is the greater of your average monthly Earnings during:

1) The tax year immediately prior to the date Disability begins; and

2) The 2 tax years immediately prior to the date Disability begins.

We will adjust Your Prior Earnings for the effect of inflation on the anniversary of the date Disability begins. Prior Earnings will be adjusted by the increase or decrease in the Cost of Living Index in the preceding calendar year, but not by more than 6% per year. In no event will Prior Earnings be reduced below the initial amount.

Residual Disability. Residual Disability is a disability of the Insured:

1) That results from an Injury or Sickness;

2) That requires Doctor's Care for which we may periodically require a Doctor's report to support a claim of Disability; and

3) During which you engage in a Gainful Occupation and, as a result of your Disability, your Loss of Earnings is at least 20%, but less than 80% of your Prior Earnings.

Residual Disability does not include the inability to work in your Regular Occupation due to:

1) Unemployment;

2) Loss of job; or

3) Job unsuitability not caused by Sickness or Injury.

If your Loss of Earnings equals or exceeds 80% of your Prior Earnings and you meet all other requirements of this definition, then you have a Total Disability, not a Residual Disability.

Residually Disabled. You have a Residual Disability.

2. RESIDUAL DISABILITY BENEFIT. We will pay you the Residual Disability Benefit for a period of Residual Disability that begins while this rider is in force. A Residual Disability Benefit applies separately to each Monthly Benefit on this contract and any attached riders.

The period for which benefits are payable:

1) Begins on the first day after the Elimination Period ends that you are Residually Disabled; and

2) Continues while you are Residually Disabled, but not beyond the end of the Benefit Period.

The Residual Disability Benefit payable for any month that the Partial Disability Benefit is payable is the amount, if any, by which:

1) The Monthly Benefit multiplied by the ratio of:

   a) Your Loss of Earnings; to

   b) Your Prior Earnings;

Exceeds

2) The Partial Disability Benefit.

The Residual Disability Benefit payable for any month that the Partial Disability Benefit is not payable is the Monthly Benefit multiplied by the ratio of:

1) Your Loss of Earnings; to

2) Your Prior Earnings.

The Residual Disability Benefit is not payable for any period of Disability for which the Total Disability Benefit is payable

3. WAIVER OF PREMIUM. In the Waiver of Premium Benefit provision of this contract, "Total Disability" is amended to read "Disability."

RESIDUAL DISABILITY BENEFIT **(continued)**

4. TIME LIMIT FOR CERTAIN DEFENSES FOR THIS RIDER. The Time Limit for Certain Defenses provision of this contract applies to this rider and its Application from the Date of Issue of this Rider.

5. TERMINATION. This rider will terminate on the earliest of:

1) The Contract Anniversary on or after your 67th birthday.

2) The date this contract terminates.

3) The date you give Notice to cancel this rider.

Signed for Thrivent Financial for Lutherans

President Bradford L Hewitt

Secretary Teresa J Rasmussen

RESIDUAL DISABILITY BENEFIT

FORM HR-IR-RDI (15)

INSURED: [JOHN DOE]
AGE: [35] SEX: [MALE]

ANNUAL PREMIUM: [$37.84]

PREMIUMS ARE PAYABLE TO THE CONTRACT ANNIVERSARY ON OR AFTER YOUR 67TH BIRTHDAY. PREMIUMS MAY CHANGE IF OTHER BENEFITS OR RIDERS INCLUDED WITH THIS CONTRACT ARE CHANGED.

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Individual Disability Income Insurance Application

☐ New Business ☐ Contract Change Contract number - ________________

Section 1 - Proposed Insured/Insured

Name (print title, first, middle, last name and suffix, as applicable)

Date of birth	Age	Sex	Residence state
		☐ Male ☐ Female	

☐ Yes ☐ No Are you a citizen of the United States of America (USA)?

☐ Yes ☐ No If no, are you a permanent resident of the USA?

Section 2 - Replacement and Other Coverage

☐ Yes ☐ No Is there other disability income or business expense coverage (either with Thrivent Financial or with another company) inforce, pending, or contemplated? **If Yes,** provide details below:

Company name			Contract number	
Elim period	Benefit period	Monthly ben amt $	Type of coverage	Prem payor

☐ Yes ☐ No Does this coverage coordinate with Social Security?

☐ Yes ☐ No Will coverage be discontinued if this Thrivent Financial contract is issued?
If Yes, replacement date -

Company name			Contract number	
Elim period	Benefit period	Monthly ben amt $	Type of coverage	Prem payor

☐ Yes ☐ No Does this coverage coordinate with Social Security?

☐ Yes ☐ No Will coverage be discontinued if this Thrivent Financial contract is issued?
If Yes, replacement date -

Company name			Contract number	
Elim period	Benefit period	Monthly ben amt $	Type of coverage	Prem payor

☐ Yes ☐ No Does this coverage coordinate with Social Security?

☐ Yes ☐ No Will coverage be discontinued if this Thrivent Financial contract is issued?
If Yes, replacement date -

Section 3 - New Business - Benefit Information

	Elimination Period	**Benefit Period**	**Monthly Benefit Amount**
Base Disability Income			
Social Insurance Offset			
Supplemental Disability Income			

Optional Riders: ☐ Residual Disability ☐ Future Purchase Option ☐ Cost of Living Indexing

Section 4 - Contract Change - Benefit Information

Base Disability Income

Monthly Benefit Amount

Increase to _____

Decrease to _____

Exercise FPO to _____

Increase Elimination Period to _____

Decrease Benefit Period to _____

Supplemental Disability Income

☐ Add

Monthly Benefit Amount _____

Elimination Period _____

Benefit Period _____

☐ Delete

Monthly Benefit Amount

Increase to _____

Decrease to _____

Exercise FPO to _____

Increase Elimination Period to _____

Decrease Benefit Period to _____

Social Insurance Offset

☐ Add

Monthly Benefit Amount _____

Elimination Period _____

Benefit Period _____

☐ Delete

Monthly Benefit Amount

Increase to _____

Decrease to _____

Exercise FPO to _____

Increase Elimination Period to _____

Decrease Benefit Period to _____

Optional Riders

Residual Disability

☐ Add

☐ Delete

Cost of Living/Indexing

☐ Add

☐ Delete

Future Purchase Option

☐ Delete

Regular Occupation

☐ Delete

Other Changes:

☐ Change to Non-Smoker/Non-Tobacco

☐ Reduce/Remove Rating

☐ Remove Endorsement

☐ Occupational Class Change

☐ Change Contract Type to Guaranteed Renewable

Section 5 - Premium Payment Information

☐ Total initial premium $ _____ ☐ No premium with application

Premium billing amount $ _____ Frequency: ☐ Annual ☐ Quarterly ☐ Monthly

Section 6 - Complete For All Applications Including Increases By FPO

1. Current employer's name | Length of current employment Years Months | Average hours worked per week -

City | State | Current occupation | Occ Class

List duties and percent of time spent on each duty.

Duty | Time % | Duty | Time %

Duty | Time % | Duty | Time %

☐ Yes ☐ No Are you enrolled in and presently contributing to Social Security?
If No, explain - _____

☐ Yes ☐ No Is this temporary employment? **If Yes,** explain -

What is your annual earned income from your current employment as reported from your most recent source of earned income? $ _____

Earned income is the total of your annual salary or wages, commissions, bonuses, fees, and income earned for services performed. Do not include income from secondary or part-time employment.

Source of annual earned income information: ☐ YTD pay stub (project annual earned income based on pay stub)
☐ W2 ☐ Tax return ☐ Other -

Are you self-employed? ☐ Yes - Provide details below. ☐ No

How is your current business organized?
☐ Sole proprietor ☐ Partnership ☐ LLC-Limited Liability Company
☐ C-Corporation ☐ S-Corporation ☐ Other - _____
If partnership or S-Corporation, what is your share percentage? _____%

Number of Employees: Full Time | Part Time

Give income attributable to your labor for the years indicated as reported for federal tax purposes.	Last Year	Prior Year
a. Net income (net profit or net loss) from Schedule C, E or K-1, or F:	$	$
b. Enter 15% of your share of gross income:	$	$

2. If current employment is less than one year, provide details below.

Previous employer's name | Length of previous employment Years Months | Annual earned income $

City | State | Previous occupation

3. If you have secondary or part-time employment, provide details below.

Employer's name | Average hours worked per week - | Annual earned income $

City | State | Secondary or part-time occupation

List duties and percent of time spent on each duty.

Duty | Time % | Duty | Time %

☐ Yes ☐ No Is secondary or part-time income from self-employment?

☐ Yes ☐ No Is secondary or part-time employment temporary? **If Yes,** explain - _____

4. Did you have unearned income (interest, dividends, net rental, alimony/maintenance, royalty income, capital gains, pension, retirement, or disability benefits received) in excess of $15,000 last year? ☐ Yes, $ _____ ☐ No

5. Net worth (assets minus liabilities), if more than $500,000 - $

6. Are you applying based on your monthly mortgage amount? ☐ Yes, provide details below. ☐ No

Minimum required monthly mortgage amount - $	Mortgage lending company	Phone

Does spouse have a disability income insurance contract with Thrivent Financial?

☐ Yes, contract number - _____ ☐ No

Section 7 - Special Requests

Section 8 - Declaration of Insurability

Height Ft In	Weight Lbs	Wt. 1 yr. ago Lbs	Details for weight loss

Name of primary care provider for the past two years - Indicate if none.

Date last consulted	Reason last consulted	
Type of treatment	**Medication prescribed**	**Date released from medical care**

1. Have you:

☐ Yes ☐ No (a) Within the past two years used tobacco or other nicotine based products?
If Yes, indicate date last used - _____

☐ Yes ☐ No (b) Within the past two years participated in any of the following:

☐ Pilot, copilot, student pilot, or crew member ☐ Auto racing ☐ Sky diving
☐ Motorcycle racing ☐ Hang gliding
☐ Ballooning ☐ Powerboat racing ☐ Rock climbing
☐ Skin/Scuba diving ☐ Mountain climbing ☐ Semi-professional/Professional sport(s)

☐ Yes ☐ No (c) Within the past three years had a driver's license suspended, revoked, plead guilty to, or been convicted of a moving traffic violation? **If Yes,** list below.

State where licensed	Driver license number

Type of Violation	MPH Over	Date

☐ Yes ☐ No (d) Within the past seven years had a life, health, disability income, or long-term care insurance application declined, postponed, rated, modified, or withdrawn? **If Yes,** list below.

Application Action	Company Name	Date	Reason

☐ Yes ☐ No 2. Have your biological parents, brothers, or sisters ever been diagnosed or medically treated by a member of the medical profession for coronary artery disease, polycystic kidney disease, Huntington's disease, or familial polyposis? **If Yes,** list below.

Disorder	Relationship To Proposed Insured	Age At Onset	Current Age	Age At Death

Place details for all "Yes" answers for questions three through 10 in Details Section.

3. Within the past 10 years, have you been diagnosed or been medically treated by a physician, chiropractor, counselor, or other member of the medical profession for:

☐ Yes ☐ No (a) disorder of the heart, circulatory, blood, or immune system (excluding Human Immunodeficiency Virus (AIDS virus))?

If high blood pressure, date of diagnosis - _____

Last blood pressure reading - _____/_____ Date of last blood pressure check - _____

Type of treatment - _____ Medication taking - _____

Care provider/Facility with records if other than primary care provider -

_____

☐ Yes ☐ No (b) abnormal growth, cyst, tumor, or cancer?

☐ Yes ☐ No (c) disorder of the respiratory system?

☐ Yes ☐ No (d) disorder of the digestive system such as the stomach, intestines, rectum, liver, gallbladder, esophagus?

☐ Yes ☐ No (e) disorder of the urinary system, such as kidneys, bladder?

☐ Yes ☐ No (f) disorder of the endocrine/hormone system (e.g. diabetes)?

☐ Yes ☐ No (g) disorder of the nervous system including psychological and psychiatric care?

☐ Yes ☐ No (h) disorder of the muscle, skin, bone, or joint?

☐ Yes ☐ No (i) disorder of the reproductive system?

☐ Yes ☐ No (j) disorder of the eyes, ears, nose, or throat?

☐ Yes ☐ No 4. Within the past 10 years, have you been advised by a physician, chiropractor, counselor, or other member of the medical profession to seek medical treatment or counseling, received medical treatment or counseling, joined Alcoholics Anonymous, Narcotics Anonymous, or other support organization for the use of alcohol or prescribed or non-prescribed drugs?

If alcohol, date last used - _____ Number of times treated - _____

Attends support organization: ☐ Yes, date last attended - _____ ☐ No

Care provider/Facility with records if other than primary care provider -

_____

If drugs, type - _____ Date last used - _____

Number of times treated - _____

Attends support organization: ☐ Yes, date last attended - _____ ☐ No

Care provider/Facility with records if other than primary care provider -

_____

☐ Yes ☐ No 5. Within the past 10 years, have you used or are you currently using amphetamines, barbiturates, cocaine, hallucinogens, heroin, marijuana, narcotics, or other habit forming drugs, except as prescribed by a physician or other member of the medical profession?

If Yes, type - _____ Date last used - _____

☐ Yes ☐ No 6. Within the past five years, have you made a claim for or received benefits, compensation or pension for any injury, sickness, disability, or impaired condition?

Date began - _____ Reason - _____

7. Other than reported above, within the past five years, have you:

☐ Yes ☐ No (a) consulted or been advised by a physician, chiropractor, counselor, or other member of the medical profession to consult a physician, chiropractor, counselor, or other member of the medical profession for any reason?

☐ Yes ☐ No (b) been medically treated or evaluated at a hospital, clinic, or other facility, or been advised by a physician, chiropractor, counselor, or other member of the medical profession to have any medical treatment, test, procedure, surgery, biopsy, hospitalization, nursing home care, or home health care not yet completed (excluding Human Immunodeficiency Virus (AIDS virus))?

☐ Yes ☐ No (c) been advised by a physician, chiropractor, counselor, or other member of the medical profession to restrict or avoid normal activities due to illness or injury?

☐ Yes ☐ No (d) taken any prescription drugs other than those previously listed? **If Yes,** list below.

Prescription Drug Used	Reason For Use	Date Last Used

☐ Yes ☐ No 8. Within the past 10 years have you been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus), Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)?

☐ Yes ☐ No 9. Other than reported above, within the past five years, have you been under the care of or are you scheduled to see a physician, chiropractor, counselor, or other member of the medical profession? **If Yes,** reason for care/appointment - ______________________ Date - __________
Care provider/Facility with records if other than primary care provider -

☐ Yes ☐ No 10. Other than reported above, within the past five years, have you been diagnosed or received medical treatment by a physician, chiropractor, counselor, or other member of the medical profession for pregnancy complications, such as toxemia, cesarean section or miscarriage?
If Yes, explain -

Section 9 - Details For Questions Answered "Yes"

Question: No/Ltr	Type of disorder, injury, test			Date of diagnosis
Date of onset	Number of occurrences	Treatment	Date of last hospitalization, nursing home care, or home health care	
Last occurrence date	Released from medical care ☐ Yes ☐ No	Date released from medical care	Surgery date	Last consultation date
Time lost from work/school	Medication(s) currently taking			
Care provider/Facility with records if other than primary care provider				

Question: No/Ltr	Type of disorder, injury, test			Date of diagnosis
Date of onset	Number of occurrences	Treatment	Date of last hospitalization, nursing home care, or home health care	
Last occurrence date	Released from medical care ☐ Yes ☐ No	Date released from medical care	Surgery date	Last consultation date
Time lost from work/school	Medication(s) currently taking			
Care provider/Facility with records if other than primary care provider				

Question: No/Ltr	Type of disorder, injury, test			Date of diagnosis
Date of onset	Number of occurrences	Treatment	Date of last hospitalization, nursing home care, or home health care	
Last occurrence date	Released from medical care ☐ Yes ☐ No	Date released from medical care	Surgery date	Last consultation date
Time lost from work/school	Medication(s) currently taking			
Care provider/Facility with records if other than primary care provider				

Additional Underwriting Information

Section 10 - Agreement and Signature

I understand and agree that:

1. I have read (or have had read to me) all statements and answers recorded on this application. They are given to obtain this insurance and are, to the best of my knowledge and belief true, complete and correctly recorded.
2. The entire application consists of this Individual Disability Income Insurance Application and all supplemental application forms required for the contract or change applied for as defined by the company. The entire application will become part of any contract issued or the contract for which a requested change has been approved.
3. No representative of the company has the authority to change or waive any question contained in the application or to modify the application in any way.
4. No representative of the company has the authority to accept risks or determine insurability for the company.
5. The date of the application is the latest of the following dates: a) The date shown on the Individual Disability Income Insurance Application; b) The date shown on any required supplemental application forms.
6. Any change in this application that will result in any change in plan of insurance, amount, age at issue, sex, class or benefits shall require my written consent.
7. If the answers on this application are incorrect or untrue, the company may have the right to deny benefits or rescind the contract. I understand that all information must be stated in the application and if not stated in the application, it is not considered given to the company.

In addition, for New Business:

No insurance will take effect unless and until:

a. A contract of insurance is issued and delivered;
b. The first full premium is paid during the lifetime of the person to be covered; and
c. The health of the person to be insured remains as stated in this application.

In addition, for Contract Change:

1. I agree that the requested change in my contract shall not become effective unless and until the required premium has been paid and the requested change has been approved by the company.
2. With regard to statements made in this application, the Time Limit For Certain Defenses provision will apply from the effective date of the contract change.

The signature below applies to all sections and statements on this application.

Signed at _____ _____
City State

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signature of proposed insured/insured and date signed

I certify that I have asked all questions and recorded all answers as they were given to me and reviewed these with the proposed insured.

To the best of my knowledge, the contract applied for ☐ is ☐ is not intended to replace any part of, or all of, another contract.

Signature of representative and date signed

Name of representative	Code number of representative

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Simplified Issue Individual Disability Income Insurance Application

Section 1 - Proposed Insured

Name (print title, first, middle, last name and suffix, as applicable)	Sex	Date of birth

Section 2 - Other Coverage and Occupation Information

☐ Yes ☐ No 1. Are you working 10 hours or more per week?*

☐ Yes ☐ No 2. Do you have individual disability income coverage (either with Thrivent Financial or with another company) inforce or pending?*

☐ Yes ☐ No 3. Do you have group disability income coverage inforce or pending?

☐ Yes ☐ No 4. Within the past two years, have you used tobacco or other nicotine products?

Current occupation	Occupation class

List duties of occupation and percentage of time spent on each duty.

Duty	Time %	Duty	Time %
Duty	Time %	Duty	Time %

Section 3 - Product Information

Base Disability Income Monthly Benefit Amount - $ _____

Elimination Period: [3 months] Benefit Period: [60 months]

Section 4 - Declaration of Insurability*

1. Have you:

☐ Yes ☐ No (a) Within the past two years participated in any of the following activities: pilot, copilot, student pilot, or crew member; auto racing, motorcycle racing, powerboat racing, hang gliding, mountain/rock climbing, ballooning, sky diving, skin/scuba diving, or semi-professional/professional sport(s)?

☐ Yes ☐ No (b) Within the past seven years had a disability income insurance application declined, postponed, rated, modified or withdrawn?

2. Within the past five years have you been diagnosed or received medical treatment by a physician, chiropractor, counselor, or other member of the medical profession for:

☐ Yes ☐ No (a) Disease or disorder of the heart, circulatory system, or kidney (excluding high blood pressure if no reading during the past 24 months above 140/90)?

☐ Yes ☐ No (b) Diabetes, chronic hepatitis, ulcerative colitis, Crohn's disease, pancreatitis, or chronic lung disorder excluding asthma?

☐ Yes ☐ No (c) Arthritis or any joint disorder, tendon disorder, fibromyalgia, chronic fatigue syndrome, or disorder of the spine?

☐ Yes ☐ No (d) Disease or disorder of the nervous system, including psychological or psychiatric care (excluding treatment for abuse-related conditions)?

☐ Yes ☐ No 3. Within the past five years have you been advised by a physician, chiropractor, counselor, or other member of the medical profession to seek medical treatment or counseling, received medical treatment or counseling, joined Alcoholics Anonymous, Narcotics Anonymous, or other support organization for the use of alcohol or prescribed or non-prescribed drugs?

☐ Yes ☐ No 4. Are you currently making a claim for or receiving benefits, compensation or pension for disability or have you been advised by a member of the medical profession to use any special medical equipment or appliance?

*Note: If you are working fewer than 10 hours per week, have individual disability income coverage in force or pending, or answered "Yes" to any question in Section 4, then full underwriting is required and this application may not be used.

Section 5 - Premium Payment Information

Total initial premium: $ _____ Frequency: ☐ Annual ☐ Quarterly ☐ Monthly

Section 6 - Special Requests

Section 7 - Agreement and Signature

I understand and agree that:

1. I have read (or have had read to me) all statements and answers recorded on this application. They are given to obtain this insurance and are, to the best of my knowledge and belief, true, complete and correctly recorded.
2. The entire application consists of this Simplified Issue Individual Disability Income Insurance Application and all supplemental application forms required for the contract applied for as defined by the company. The entire application will become part of any contract issued.
3. No representative of the company has the authority to waive any question contained in the application or to modify the application in any way.
4. No representative is authorized to change or waive any terms of this agreement or to make any promises or representations other than those contained in this agreement.
5. This application will be accepted after a fully underwritten life insurance application of $100,000 or greater is assessed at a standard or better risk class.
6. Except as provided in the Conditional Temporary Individual Disability Income Insurance Agreement and Receipt for Payment which is issued if the first premium for the contract applied for is paid, no insurance will take effect unless and until: a) A contract of insurance is issued and delivered; b) The first total initial premium is paid; and c) The health of the person to be covered remains as stated in this application.
7. The date of the application is the date shown on this Simplified Issue Individual Disability Income Insurance Application.
8. If the answers on this application are incorrect or untrue, the company may have the right to deny benefits or rescind the contract. I understand that all information must be stated in the application and if not stated in the application, it is not considered given to the company.

My signature applies to all sections and statements in this application.

Signed at _____ _____
City State

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signature of proposed insured and date signed

I certify that I have asked all questions and recorded all answers as they were given to me and reviewed these with the proposed insured.

Signature of representative and date signed

Name of representative	Code number of representative

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Supplement to Application for Insurance

Medical Details - Continuation

Name (print title, first, middle, last name and suffix, as applicable)

Question: No/Ltr	Type of disorder, injury, test			Date of diagnosis	
Date of onset	Number of occurrences	Treatment	Date of last hospitalization, nursing home care, or home health care		
Last occurrence date	Released from medical care ☐ Yes ☐ No	Date released from medical care	Surgery date	Last consultation date	
Time lost from work/school	Medication(s) currently taking				
Care provider/Facility with records if other than primary care provider					

Question: No/Ltr	Type of disorder, injury, test			Date of diagnosis	
Date of onset	Number of occurrences	Treatment	Date of last hospitalization, nursing home care, or home health care		
Last occurrence date	Released from medical care ☐ Yes ☐ No	Date released from medical care	Surgery date	Last consultation date	
Time lost from work/school	Medication(s) currently taking				
Care provider/Facility with records if other than primary care provider					

Question: No/Ltr	Type of disorder, injury, test			Date of diagnosis	
Date of onset	Number of occurrences	Treatment	Date of last hospitalization, nursing home care, or home health care		
Last occurrence date	Released from medical care ☐ Yes ☐ No	Date released from medical care	Surgery date	Last consultation date	
Time lost from work/school	Medication(s) currently taking				
Care provider/Facility with records if other than primary care provider					

Question: No/Ltr	Type of disorder, injury, test			Date of diagnosis	
Date of onset	Number of occurrences	Treatment	Date of last hospitalization, nursing home care, or home health care		
Last occurrence date	Released from medical care ☐ Yes ☐ No	Date released from medical care	Surgery date	Last consultation date	
Time lost from work/school	Medication(s) currently taking				
Care provider/Facility with records if other than primary care provider					

Question: No/Ltr	Type of disorder, injury, test				Date of diagnosis
Date of onset	Number of occurrences	Treatment	Date of last hospitalization, nursing home care, or home health care		
Last occurrence date	Released from medical care ☐ Yes ☐ No	Date released from medical care		Surgery date	Last consultation date
Time lost from work/school	Medication(s) currently taking				
Care provider/Facility with records if other than primary care provider					

Question: No/Ltr	Type of disorder, injury, test				Date of diagnosis
Date of onset	Number of occurrences	Treatment	Date of last hospitalization, nursing home care, or home health care		
Last occurrence date	Released from medical care ☐ Yes ☐ No	Date released from medical care		Surgery date	Last consultation date
Time lost from work/school	Medication(s) currently taking				
Care provider/Facility with records if other than primary care provider					

Question: No/Ltr	Type of disorder, injury, test				Date of diagnosis
Date of onset	Number of occurrences	Treatment	Date of last hospitalization, nursing home care, or home health care		
Last occurrence date	Released from medical care ☐ Yes ☐ No	Date released from medical care		Surgery date	Last consultation date
Time lost from work/school	Medication(s) currently taking				
Care provider/Facility with records if other than primary care provider					

I have read (or have had read to me) the statements and answers recorded on this Supplement to Application for Insurance. To the best of my knowledge and belief, they are true, complete and correctly recorded and shall be a basis of any contract issued or for which a change has been requested. My signature applies to all sections and statements on this Supplement to Application for Insurance.

Signed at ______________________________ __________
City State

Signature of proposed insured/insured and date signed

Signature of representative and date signed

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Conditional Temporary Individual Disability Income Insurance Agreement and Receipt for Payment

Read this agreement and receipt carefully.

Make all checks payable to us. Do not make checks payable to the representative. Do not leave the payee blank.

This agreement is void if any check given for payment is not honored.

Name of proposed insured/insured (print title, first, middle, last name and suffix, as applicable)

Amount received	Received from	Source of payment
$		

None of our representatives or other agents acting on our behalf are authorized to change or waive any terms of this agreement or make any promises or representations other than those contained in this agreement.

Signature of representative and date signed

Requirements for Conditional Insurance

If each and every one of the following conditions are met, insurance coverage under this agreement is provided according to the terms and conditions of the contract applied for that are not in conflict with this agreement:

1. All material representations in the application are true and complete.
2. The first full standard premium for the interval selected has been paid.
3. You are an insurable risk for the product and amount of insurance applied for or offered by us if other than applied for. We will determine the insurability of the proposed insured on the later of the following two dates:
   a) the date the application is completed and signed.
   b) the date the declaration of insurability and all exams or tests are completed for the proposed insured in accordance with our published underwriting guidelines.
4. All requirements necessary for underwriting are completed within 60 days from the date of application.
5. This agreement has not terminated.

If one or more of the above conditions is not met, our liability is limited to the premium submitted.

In no event will any insurance ever be in force unless the proposed insured is an acceptable risk under our rules.

Exclusions

Coverage is excluded under this agreement for any disability or loss resulting from any of the following:

1. Operating, descending from or riding in an aircraft being used for private or instructional purposes.
2. Suicide or attempted suicide or intentionally self-inflicted injury.
3. Any disease, disorder, activity or condition that would be excluded by endorsement under our underwriting rules, guidelines, or policies or excluded or limited under provisions of the contract applied for.

Termination of Conditional Insurance

Coverage under this agreement ends on the earliest of the following dates:

1. The date we issue the contract of disability income insurance applied for.
2. The date we refund the premium paid.
3. The date your application is declined or closed as an incomplete application.
4. If we do not issue the coverage as applied for, and we make you a counter-offer, the date our counter-offer is accepted, rejected or expires.

Definitions

application:	all application forms that we require for the product applied for.
date of the application:	the date shown on the application for new business/contract change or on the declaration of insurability, whichever is later.
our, we, us:	Thrivent Financial for Lutherans
you, your:	proposed insured/insured

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Supplement to Application for Insurance

Prescription Drugs - Continuation

Name (print title, first, middle, last name and suffix, as applicable)

Prescription Drug Used	Date Last Used	Reason for Use

I have read (or have had read to me) the statements and answers recorded on this Supplement to Application for Insurance. To the best of my knowledge and belief, they are true, complete and correctly recorded and shall be a basis of any contract issued or for which a change has been requested. My signature applies to all sections and statements on this Supplement to Application for Insurance.

Signed at _____ _____
City State

Signature of proposed insured/insured and date signed

Signature of representative and date signed

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Supplement to Application for Insurance

Replacement and Other Coverage - Continuation

Name (print title, first, middle, last name and suffix, as applicable)

Company name				Contract number	
Elim period	Benefit period	Monthly ben amt $	Type of coverage	Prem payor	

☐ Yes ☐ No Does this coverage coordinate with Social Security?
☐ Yes ☐ No Will coverage be discontinued if this Thrivent Financial contract is issued?
If Yes, replacement date -

Company name			Contract number	
Elim period	Benefit period	Monthly ben amt $	Type of coverage	Prem payor

☐ Yes ☐ No Does this coverage coordinate with Social Security?
☐ Yes ☐ No Will coverage be discontinued if this Thrivent Financial contract is issued?
If Yes, replacement date -

Company name			Contract number	
Elim period	Benefit period	Monthly ben amt $	Type of coverage	Prem payor

☐ Yes ☐ No Does this coverage coordinate with Social Security?
☐ Yes ☐ No Will coverage be discontinued if this Thrivent Financial contract is issued?
If Yes, replacement date -

Company name			Contract number	
Elim period	Benefit period	Monthly ben amt $	Type of coverage	Prem payor

☐ Yes ☐ No Does this coverage coordinate with Social Security?
☐ Yes ☐ No Will coverage be discontinued if this Thrivent Financial contract is issued?
If Yes, replacement date -

I have read (or have had read to me) the statements and answers recorded on this Supplement to Application for Insurance. To the best of my knowledge and belief, they are true, complete and correctly recorded and shall be a basis of any contract issued or for which a change has been requested. My signature applies to all sections and statements on this Supplement to Application for Insurance.

Signed at ______________________ ________
City State

Signature of proposed insured/insured and date signed

Signature of representative and date signed

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Endorsement Eliminating Coverage

Name of proposed insured/insured	Contract number

This Endorsement is attached to and made a part of the contract designated above. The effective date is the date of issue for new business or contract change, or the date of reinstatement. The provision(s) of this Endorsement Eliminating Coverage are in lieu of any contract provision(s) to the contrary.

In consideration of the issue or reinstatement of this contract, it is hereby understood and agreed, by and between the insured and Thrivent Financial, the contract designated above shall not cover any loss nor shall any payments be made under the contract for any loss resulting from:

[Disease or disorder of the left knee, including any complications thereof]

[Injury sustained while operating or riding in a motor vehicle engaged in racing or speed-testing]

Signature of proposed insured/insured and date signed

Teresa J. Rasmussen, Secretary
Thrivent Financial for Lutherans

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Disability Income Application Change

Name of proposed insured/insured	Date of application	Contract number

I change my application with Thrivent Financial as follows:

[Answer to Question 3b in Section 8 is no.]

[The Residual Disability Benefit Rider has been deleted.]

[The Base Disability Income Benefit elimination period has been changed to 6 months.]

I hereby agree that this form is part of the original application and shall be binding on any person who shall have or claim any interest in any contract issued on the basis of such application. I hereby agree that all representations made are true and complete to the best of my knowledge and belief on the date signed.

Signed at _____ _____
City State

Signature of proposed insured/insured and date signed

Print name of proposed insured/insured

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Statement of Good Health

Application/Contract number	Date of application

Name of proposed insured/insured (print title, first, middle, last name and suffix, as applicable)

Supplementing the application/contract with Thrivent Financial or its affiliates, I hereby declare that the statements and answers in the application:

- were true and complete when originally made, and
- are true and complete and the same as if made at this time.

Since the date of application, the proposed insured has not:

- Consulted or been advised by a physician, chiropractor, counselor, or other member of the medical profession to consult a physician, chiropractor, counselor, or other member of the medical profession for any reason.
- Been medically treated or evaluated at a hospital, clinic or other facility or been advised by a physician, chiropractor, counselor, or other member of the medical profession to have any medical treatment, test, procedure, surgery, biopsy, hospitalization, nursing home care, or home health care.
- Been advised by a physician, chiropractor, counselor or other member of the medical profession to restrict or avoid normal activities due to illness or injury.
- Other than as specifically stated on the application:
  - Taken any prescription medications
  - Participated in any of the following activities: pilot, copilot, student pilot, or crew member; auto racing, motorcycle racing, powerboat racing, hang gliding, mountain/rock climbing, ballooning, sky diving, skin/scuba diving, or semi-professional/professional sport(s)
  - Used cigarettes, tobacco or other nicotine based products
  - Had any change in occupation
- Had an application for insurance or reinstatement of insurance declined or modified.

Provide details for any exceptions to the above representations.

Details for exceptions and full name and address of any doctors.

The representations above are true to the best of my knowledge. Any false or incomplete statements could result in the loss of coverage. This Statement of Good Health will become part of the insurance contract.

Signature of proposed insured/insured and date signed

Signature of representative and date signed

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Supplement to Application for Insurance

Application Action - Continuation

Name (print title, first, middle, last name and suffix, as applicable)

Application Action	Company Name	Date	Reason

I have read (or have had read to me) the statements and answers recorded on this Supplement to Application for Insurance. To the best of my knowledge and belief, they are true, complete and correctly recorded and shall be a basis of any contract issued or for which a change has been requested. My signature applies to all sections and statements on this Supplement to Application for Insurance.

Signed at _____ _____
City State

Signature of proposed insured/insured and date signed

Signature of representative and date signed

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Supplement to Application for Insurance

Moving Traffic Violations - Continuation

Name (print title, first, middle, last name and suffix, as applicable)

Type of Violation	MPH Over	Date

I have read (or have had read to me) the statements and answers recorded on this Supplement to Application for Insurance. To the best of my knowledge and belief, they are true, complete and correctly recorded and shall be a basis of any contract issued or for which a change has been requested. My signature applies to all sections and statements on this Supplement to Application for Insurance.

Signed at _____ _____
City State

Signature of proposed insured/insured and date signed

Signature of representative and date signed

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Member ID
Contract number

Individual Disability Income Insurance Contract Reinstatement Application

Section 1 - Complete for all insured(s) on the contract

Name	Date of Birth	Current Height	Current Weight	Weight 1 yr. ago or at birth if under age 1	Details for Weight Loss
		Ft In	Lbs	Lbs Oz	
		Ft In	Lbs	Lbs Oz	
		Ft In	Lbs	Lbs Oz	
		Ft In	Lbs	Lbs Oz	

Section 2 - Medical History

1. Within the past five years, has any insured:

☐ Yes ☐ No (a) consulted or been advised by a physician, chiropractor, counselor, or other member of the medical profession to consult a physician, chiropractor, counselor, or other member of the medical profession for any reason?

☐ Yes ☐ No (b) been medically treated or evaluated at a hospital, clinic or other facility or been advised by a physician, chiropractor, counselor, or other member of the medical profession to have any medical treatment, test, procedure, surgery, biopsy, hospitalization, nursing home care, or home health care not yet completed?

☐ Yes ☐ No (c) been advised by a physician, chiropractor, counselor, or other member of the medical profession to restrict or avoid normal activities due to illness or injury?

☐ Yes ☐ No (d) taken any prescription drugs?

Place details for all 'Yes' answers below:

Include: Question number, insured name, name and address of physician/medical facility, diagnosis, date of diagnosis and consultations, consultation details, treatment

☐ Yes ☐ No 2. Within the past two years, has any insured participated in any of the following:

☐ Pilot, copilot, student pilot or crew member
☐ Auto racing
☐ Sky diving
☐ Motorcycle racing
☐ Hang gliding
☐ Ballooning
☐ Powerboat racing
☐ Rock climbing
☐ Skin/Scuba diving
☐ Mountain climbing
☐ Semi-professional/Professional sport(s)

Name	Activity	Date Began	Last Participation Date

Section 2 - Medical History (continued)

☐ Yes ☐ No 3. Does any insured currently use, or within the past 10 years has any insured used, tobacco or other nicotine products?

Name	Type of Tobacco/Nicotine Product	Quantity	Frequency	Date Last Used

Section 3 - Additional Information

Section 4 - Agreement and Signature

I understand and agree that:

1. I have read (or have had read to me) all statements and answers recorded on this application. To the best of my knowledge and belief, they are true, complete and correctly recorded and shall be a basis of the reinstatement of the contract.
2. This application will become part of the insurance contract if the reinstatement is approved by the company.
3. No Representative of the company has the authority to waive any question contained in the application or to modify the application in any way.
4. No Representative is authorized to change or waive any terms of this agreement or to make any promises or representations other than those contained in this agreement.
5. The reinstatement must be made during the lifetime of all persons for whom the contract is to provide coverage and while the facts concerning the insurability of all persons for whom the contract is to provide coverage are the same as described in this application.
6. The reinstatement of the contract shall not become effective unless and until the required premium has been paid and the reinstatement has been approved by the company.
7. With regard to statements made in the application, the Time Limit For Certain Defenses provision of the contract will apply from the date this application is approved.
8. If the answers on this application are incorrect or untrue, the company may have the right to deny benefits or rescind the contract.

The signature below applies to all sections and statements on this application.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signature of insured and date signed

Signature of other insured and date signed

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Disability Income Insurance
Outline of Coverage

Form H-IN-NCDI (15)

1. **READ YOUR CONTRACT CAREFULLY** - This outline of coverage provides a very brief description of the important features of your contract. This is not the insurance contract and only the actual contract provisions will control. The contract itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR CONTRACT CAREFULLY!

2. Disability income insurance is designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the contract. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

3. **BENEFITS PROVIDED BY YOUR CONTRACT.**

a) Terms Used in Base Contract and Optional Benefit Riders.

Monthly Benefit. The monthly amount we will pay for a period of Total Disability.

Elimination Period. The number of days at the beginning of a period of disability for which no monthly disability benefits are payable. The Elimination Period starts on the first day you are disabled.

Benefit Period. The maximum number of months for which we will pay benefits for any separate period of disability. The Benefit Period begins at the end of the Elimination Period.

b) Base Contract.

Monthly Benefit for Total Disability: $_____

For Partial Disability we will pay you one-half of the Monthly Benefit payable for Total Disability for not more than six months or to the end of the Benefit Period if earlier.

Elimination Period: _____

Benefit Period: _____

Base Contract Premium: $_____

Transplants.

If you become disabled as a result of a transplant of a part of your body to the body of another while the contract is in force, we will consider your disability to be a result of sickness.

Rehabilitation.

While you are disabled, you may request reimbursement from us for participation in a rehabilitation program designed to help you return to work.

Waiver of Premium Benefit.

If Total Disability is continuous for 90 days (residual disability or partial disability can also qualify if a Residual Disability Benefit Rider is attached) we will waive any premiums which come due while total disability continues until monthly disability benefits are no longer payable.

OPTIONAL BENEFIT RIDERS.

☐ **Supplemental Disability Income Benefit Rider, Form HR-IU-SDI (15)**

This rider provides an additional monthly disability benefit if a covered injury or sickness causes you to be disabled.

Monthly Benefit for Total Disability: $_____

For Partial Disability we will pay you one-half of the Monthly Benefit payable for Total Disability for not more than 6 months or to the end of the Benefit Period if earlier.

Elimination Period: _____

Benefit Period: _____

Premium: $_____ Per _____

☐ **Social Insurance Offset Benefit Rider, Form HR-IO-SIO (15)**

This rider provides a monthly disability benefit if you are disabled. Your Maximum Monthly Benefit will be reduced by the amount payable from the Social Security disability program, workers' compensation or occupational disease act or law of any government, the Railroad Retirement Act, any Civil Service or federal employee programs, or the U.S. Department of Veterans Affairs disability compensation program. You must make timely application for any social insurance benefits for disability for which you may be eligible and appeal any benefit denials as we may request.

Monthly Benefit for Total Disability = Maximum Monthly Benefit $_____ less (offset by) any social insurance benefits payable.

For Partial Disability we will pay you one-half of the Monthly Benefit payable for Total Disability for not more than 6 months or to the end of the Benefit Period if earlier.

Elimination Period: _____

Benefit Period: _____

Premium: $_____ Per_____

☐ **Residual Disability Benefit Rider, Form HR-IR-RDI (15)**

This rider provides a monthly disability benefit if you are disabled and your loss of earnings is at least 20% but less than 80% of your prior earnings. We will pay you a percentage of the Monthly Benefit for the contract and any applicable riders, depending on the percentage of earnings lost. For the first 6 months that Partial Disability benefits are payable, the combined benefit payable under this rider and the Partial Disability benefit will be at least 50% of the Monthly Benefit. No benefits are payable under this rider while Total Disability benefits are being paid.

Premium: $_____ Per_____

☐ **Cost of Living Indexing Benefit Rider, Form HR-IX-COL (15)**

During a disability, this rider adjusts monthly disability benefits with benefit periods of 60 months or longer by changes in the Consumer Price Index for All Urban Consumers. The first adjustment will occur on the anniversary of the first day of disability. Additional adjustments will occur on each subsequent anniversary while disability continues and the rider is in force. The adjustments are based on the total percentage change in the index from the date of disability but are limited to an increase of the smaller of:

1) 6% compounded annually from the start of disability; and

2) Two times since the start of disability.

No adjustments will be made on an anniversary of the first day of disability if the index stays the same as or decreases from the index on the previous anniversary.

Premium: $_____ Per_____

☐ **Future Purchase Option Benefit Rider, Form HR-IF-FPO (15)**

This rider gives you the option to buy additional disability income insurance on each purchase option date without evidence of insurability as to your health. These dates occur every three years until the 15th contract anniversary or the contract anniversary at age 55, if earlier. An additional purchase option date will occur in any year that you have group long-term disability insurance coverage that terminates. Each purchase is subject to certain conditions including qualifying under our financial underwriting limits and issue and participation limits then in use. The sum of all purchases may not exceed the total purchase option limit set forth in the rider.

Premium: $_____ Per_____

4. **EXCLUSIONS AND LIMITATIONS.**

EXCLUSIONS.

The contract does not pay benefits for:

1) Disability or any other loss that results from any of the following:

a) Pre-existing conditions during the first 24 months after the date of issue, unless they are disclosed in the application and not excluded from coverage by name or specific description;

b) Normal pregnancy, child birth, or elective abortion. However, benefits will not be denied in the event of disability due to complications of pregnancy;

c) Intentionally self-inflicted injury;

d) Attempted suicide;

e) Any act of war, declared or undeclared, or any act incident to war;

f) Any disease, disorder, activity or condition that was, as a result of the underwriting process, excluded in the contract by name or specific description;

g) Commission of or attempt to commit a felony;

h) Being engaged in an illegal occupation;

i) The suspension, revocation or surrender of your professional license to practice in your occupation.

2) Any period during which you are legally incarcerated in a penal or correctional institution for more than seven days or during a period of legal detainment of more than seven days where the period of incarceration or legal detainment results in your inability to meet any work requirements contained in the definitions of disability set forth in the contract.

3) Disability while you are residing outside of the United States, its territories and possessions.

Concurrent Disabilities.

You will not be entitled to benefits for more than one disability during the same period of time or concurrent Total and Partial Disabilities.

Suspension of Coverage While in Military Service.

If you enter active military duty for a period of at least three consecutive months, you may suspend coverage and stop paying premiums while it is suspended. If after five years from the date of suspension coverage has not resumed, the contract will be terminated.

LIMITATIONS.

1) Mental/Nervous Disorders, Substance Abuse/Chemical Dependency.

For disability resulting from mental/nervous disorders or substance abuse/chemical dependency, your monthly disability benefits for all such disabilities are limited during the life of the contract to a total of 24 monthly payments. However, this limitation will not apply:

a) While you are confined as an inpatient in a hospital for treatment of a mental/nervous disorder and/or substance abuse/chemical dependency; or

b) If your mental/nervous disorder is a result of stroke, physical trauma, or Alzheimer's Disease.

2) Self-Reported Symptoms.

For disability resulting from a specific injury or sickness determined primarily from self-reported symptoms, your monthly disability benefits for all such disabilities are limited during the life of the contract to a total of 24 monthly payments.

5. **RENEWABILITY.**

a) Your contract is **Noncancellable** until the contract anniversary on or after your 67th birthday. Except for our limited right to increase premiums for the Social Insurance Offset Benefit Rider, if any, we may not change the premiums.

b) Your contract is **Conditionally Renewable** on a limited basis beyond the contract anniversary that is on or after your 67th birthday. Only the base contract disability benefits will continue. The Waiver of Premium Benefit will no longer apply and no riders may be continued. The Benefit Period will be 12 months, the Elimination Period will be 90 days or the Elimination Period for the base contract, if shorter, and premiums for each year of renewal will be based on your age and our rates in use at that time.

You may renew the contract each year if you have not been disabled at any time since the last contract anniversary, you are working at least 30 hours per week in a gainful occupation and have been for at least 10 out of the past 12 months, the premium is paid on time, and you have not reached your 75th birthday.

Extension of Benefits.

Coverage will be continued if you are disabled when your contract terminates on any contract anniversary on or after your 67th birthday, provided you are within a benefit period and less than 12 months of benefits have been paid. Coverage will continue until the earliest of:

a) The date a new period of disability begins;

b) The date the benefit period ends for this disability; and

c) The date 12 months of benefits have been paid.

Misstatement of Age or Sex.

If your age or sex has been misstated, any amount payable will be that which the premiums paid would have bought at the correct age and sex.

Total Premium: $_____ Per_____

Each contract has a 31-day grace period.

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Thrivent Financial for Lutherans
4321 N. Ballard Road, Appleton, WI 54919-0001
Thrivent.com · 800-847-4836

Disability Income Insurance
Outline of Coverage

Form H-IG-GRDI (15)

1. **READ YOUR CONTRACT CAREFULLY** - This outline of coverage provides a very brief description of the important features of your contract. This is not the insurance contract and only the actual contract provisions will control. The contract itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR CONTRACT CAREFULLY!

2. Disability income insurance is designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the contract. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

3. **BENEFITS PROVIDED BY YOUR CONTRACT.**

a) Terms Used in Base Contract and Optional Benefit Riders.

Monthly Benefit. The monthly amount we will pay for a period of Total Disability.

Elimination Period. The number of days at the beginning of a period of disability for which no monthly disability benefits are payable. The Elimination Period starts on the first day you are disabled.

Benefit Period. The maximum number of months for which we will pay benefits for any separate period of disability. The Benefit Period begins at the end of the Elimination Period.

b) Base Contract.

Monthly Benefit for Total Disability: $_____

For Partial Disability we will pay you one-half of the Monthly Benefit payable for Total Disability for not more than six months or to the end of the Benefit Period if earlier.

Elimination Period: _____

Benefit Period: _____

Base Contract Premium: $_____

Transplants.

If you become disabled as a result of a transplant of a part of your body to the body of another while the contract is in force, we will consider your disability to be a result of sickness.

Rehabilitation.

While you are disabled, you may request reimbursement from us for participation in a rehabilitation program designed to help you return to work.

Waiver of Premium Benefit.

If Total Disability is continuous for 90 days (residual disability or partial disability can also qualify if a Residual Disability Benefit Rider is attached) we will waive any premiums which come due while total disability continues until monthly disability benefits are no longer payable.

OPTIONAL BENEFIT RIDERS.

☐ **Supplemental Disability Income Benefit Rider, Form HR-IU-SDI (15)**

This rider provides an additional monthly disability benefit if a covered injury or sickness causes you to be disabled.

Monthly Benefit for Total Disability: $_____

For Partial Disability we will pay you one-half of the Monthly Benefit payable for Total Disability for not more than 6 months or to the end of the Benefit Period if earlier.

Elimination Period: _____

Benefit Period: _____

Premium: $_____ Per _____

☐ **Social Insurance Offset Benefit Rider, Form HR-IO-SIO (15)**

This rider provides a monthly disability benefit if you are disabled. Your Maximum Monthly Benefit will be reduced by the amount payable from the Social Security disability program, workers' compensation or occupational disease act or law of any government, the Railroad Retirement Act, any Civil Service or federal employee programs, or the U.S. Department of Veterans Affairs disability compensation program. You must make timely application for any social insurance benefits for disability for which you may be eligible and appeal any benefit denials as we may request.

Monthly Benefit for Total Disability = Maximum Monthly Benefit $_____ less (offset by) any social insurance benefits payable.

For Partial Disability we will pay you one-half of the Monthly Benefit payable for Total Disability for not more than 6 months or to the end of the Benefit Period if earlier.

Elimination Period: _____

Benefit Period: _____

Premium: $_____ Per_____

☐ **Residual Disability Benefit Rider, Form HR-IR-RDI (15)**

This rider provides a monthly disability benefit if you are disabled and your loss of earnings is at least 20% but less than 80% of your prior earnings. We will pay you a percentage of the Monthly Benefit for the contract and any applicable riders, depending on the percentage of earnings lost. For the first 6 months that Partial Disability benefits are payable, the combined benefit payable under this rider and the Partial Disability benefit will be at least 50% of the Monthly Benefit. No benefits are payable under this rider while Total Disability benefits are being paid.

Premium: $_____ Per_____

☐ **Cost of Living Indexing Benefit Rider, Form HR-IX-COL (15)**

During a disability, this rider adjusts monthly disability benefits with benefit periods of 60 months or longer by changes in the Consumer Price Index for All Urban Consumers. The first adjustment will occur on the anniversary of the first day of disability. Additional adjustments will occur on each subsequent anniversary while disability continues and the rider is in force. The adjustments are based on the total percentage change in the index from the date of disability but are limited to an increase of the smaller of:

1) 6% compounded annually from the start of disability; and

2) Two times since the start of disability.

No adjustments will be made on an anniversary of the first day of disability if the index stays the same as or decreases from the index on the previous anniversary.

Premium: $_____ Per_____

☐ **Future Purchase Option Benefit Rider, Form HR-IF-FPO (15)**

This rider gives you the option to buy additional disability income insurance on each purchase option date without evidence of insurability as to your health. These dates occur every three years until the 15th contract anniversary or the contract anniversary at age 55, if earlier. An additional purchase option date will occur in any year that you have group long-term disability insurance coverage that terminates. Each purchase is subject to certain conditions including qualifying under our financial underwriting limits and issue and participation limits then in use. The sum of all purchases may not exceed the total purchase option limit set forth in the rider.

Premium: $_____ Per_____

4. **EXCLUSIONS AND LIMITATIONS.**

EXCLUSIONS.

The contract does not pay benefits for:

1) Disability or any other loss that results from any of the following:

a) Pre-existing conditions during the first 24 months after the date of issue, unless they are disclosed in the application and not excluded from coverage by name or specific description;

b) Normal pregnancy, child birth, or elective abortion. However, benefits will not be denied in the event of disability due to complications of pregnancy;

c) Intentionally self-inflicted injury;

d) Attempted suicide;

e) Any act of war, declared or undeclared, or any act incident to war;

f) Any disease, disorder, activity or condition that was, as a result of the underwriting process, excluded in the contract by name or specific description;

g) Commission of or attempt to commit a felony;

h) Being engaged in an illegal occupation;

i) The suspension, revocation or surrender of your professional license to practice in your occupation.

2) Any period during which you are legally incarcerated in a penal or correctional institution for more than seven days or during a period of legal detainment of more than seven days where the period of incarceration or legal detainment results in your inability to meet any work requirements contained in the definitions of disability set forth in the contract.

3) Disability while you are residing outside of the United States, its territories and possessions.

Concurrent Disabilities.

You will not be entitled to benefits for more than one disability during the same period of time or concurrent Total and Partial Disabilities.

Suspension of Coverage While in Military Service.

If you enter active military duty for a period of at least three consecutive months, you may suspend coverage and stop paying premiums while it is suspended. If after five years from the date of suspension coverage has not resumed, the contract will be terminated.

LIMITATIONS.

1) Mental/Nervous Disorders, Substance Abuse/Chemical Dependency.

For disability resulting from mental/nervous disorders or substance abuse/chemical dependency, your monthly disability benefits for all such disabilities are limited during the life of the contract to a total of 24 monthly payments. However, this limitation will not apply:

a) While you are confined as an inpatient in a hospital for treatment of a mental/nervous disorder and/or substance abuse/chemical dependency; or

b) If your mental/nervous disorder is a result of stroke, physical trauma, or Alzheimer's Disease.

2) Self-Reported Symptoms.

For disability resulting from a specific injury or sickness determined primarily from self-reported symptoms, your monthly disability benefits for all such disabilities are limited during the life of the contract to a total of 24 monthly payments.

5. **RENEWABILITY.**

a) Your contract is **Guaranteed Renewable** until the contract anniversary on or after your 67th birthday. We reserve the right to change premium rates by class.

b) Your contract is **Conditionally Renewable** on a limited basis beyond the contract anniversary that is on or after your 67th birthday. Only the base contract disability benefits will continue. The Waiver of Premium Benefit will no longer apply and no riders may be continued. The Benefit Period will be 12 months, the Elimination Period will be 90 days or the Elimination Period for the base contract, if shorter, and premiums for each year of renewal will be based on your age and our rates in use at that time.

You may renew the contract each year if you have not been disabled at any time since the last contract anniversary, you are working at least 30 hours per week in a gainful occupation and have been for at least 10 out of the past 12 months, the premium is paid on time, and you have not reached your 75th birthday.

Extension of Benefits.

Coverage will be continued if you are disabled when your contract terminates on any contract anniversary on or after your 67th birthday, provided you are within a benefit period and less than 12 months of benefits have been paid. Coverage will continue until the earliest of:

a) The date a new period of disability begins;

b) The date the benefit period ends for this disability; and

c) The date 12 months of benefits have been paid.

Misstatement of Age or Sex.

If your age or sex has been misstated, any amount payable will be that which the premiums paid would have bought at the correct age and sex.

Total Premium: $_____ Per_____

Each contract has a 31-day grace period.

SERFF Tracking #:	*THRV-130042399*	***State Tracking #:***		***Company Tracking #:***	

State:	*District of Columbia*	***Filing Company:***	*Thrivent Financial for Lutherans*
TOI/Sub-TOI:	*H11I Individual Health - Disability Income/H11I.008 Combined Short Term and Long Term - Unrelated to marketing with employer or association groups*		
Product Name:	*Individual Disability Income*		
Project Name/Number:	*G-Series/*		

Supporting Document Schedules

Satisfied - Item:	Readability
Comments:	
Attachment(s):	READABILITY CERTIFICATION - generic.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Statement of Variability
Comments:	
Attachment(s):	DI Contract SOV Final - generic.pdf filing SOV applications - generic.pdf
Item Status:	
Status Date:	

READABILITY CERTIFICATION

I certify that the following form has the below listed readability score as calculated by Flesch Reading Ease Test.

Form	Flesch Score
H-IN-NCDI (15)	53
H-IG-GRDI (15)	53
HR-IF-FPO (15)	52
HR-IX-COL (15)	55
HR-IO-SIO (15)	60
HR-IU-SDI (15)	56
HR-IR-RDI (15)	55
28848	50
28849	50
28855	55
28857 scored w H-IN-NCDI (15) or H-IG-GRDI (15)	53
28858	70
28859	56
28861 scored w H-IN-NCDI (15) or H-IG-GRDI (15)	53
28872	56
28874 scored w H-IN-NCDI (15) or H-IG-GRDI (15)	53
28875	70
28876	70
28877 scored w H-IN-NCDI (15) or H-IG-GRDI (15)	52

Signature of Company Officer

Jeffrey B. Little, Vice President, Solutions Operations
Typed Name and Title

Thrivent Financial for Lutherans
Company Name

August 28, 2015

THRIVENT FINANCIAL FOR LUTHERANS

STATEMENT OF VARIABILITY DTD 8-27-15

Disability Income Insurance, Form H-IN-NCDI (15)

The following items have been bracketed to indicate that the information may be different in different contracts or may be subject to change.

Items on Face Page

1. Service Center **address** and **telephone number** may be changed.
2. **Officers' signatures** will change if new officers are elected.
3. **INSURED, AGE, SEX, CONTRACT NUMBER,** and **DATE OF ISSUE** are specific to each insured. This wording also appears on Page 3.

Items on page 3

4. **ANNUAL PREMIUM** for the Basic Benefit is based on the insured's age, sex, occupational class, tobacco status, premium rating, monthly benefit, elimination period, and benefit period.
5. **OCCUPATIONAL CLASS:** 1A, 2A, 3A, 3M, 4A, 4M, or 5A
6. **TOBACCO STATUS:** Non-Tobacco or Tobacco
7. **PREMIUM RATING:** Standard, or a percentage ranging from 40%-100%
8. **MONTHLY BENEFIT:** $50 – $18,000
9. **ELIMINATION PERIOD:** 1 month, 2 months, 3 months, 6 months, 12 months, 24 months
    - If a Benefit Period of 12 months or less is selected, the Elimination Period selected cannot be greater than 3 months.
10. **BENEFIT PERIOD:** 6 months, 12 months, 24 months, 60 months, 10 years, To Age 67
11. **ADDITIONAL BENEFITS:** This section contains the list of all riders, and the annual premium associated with each rider, that are included with this contract. The section is not shown if no riders are attached. Possible riders are:
    FORM HR-IF-FPO (15)
    FORM HR-IO-SIO (15)
    FORM HR-IR-RDI (15)
    FORM HR-IU-SDI (15)
    FORM HR-IX-COL (15)
12. **TOTAL ANNUAL PREMIUM:** The sum of the premium for the Basic Benefit and the premiums for any additional riders.
13. **INTERVAL OF PAYMENT:** Annual, Quarterly, Monthly
14. **INITIAL PREMIUM:** The first premium paid for the Interval of Payment selected.
15. **Benefit Period Footnote:**
    - "BUT NOT BEYOND AGE 67." will appear if the Benefit Period is not To Age 67.
    - "HOWEVER, IF YOU ARE DISABLED AT AGE 67 AND LESS THAN 12 MONTHS OF BENEFIT HAVE BEEN PAID, THE BENEFIT PERIOD WILL BE 12 MONTHS." will appear if the Benefit Period is 12 months, 24 months, 60 months, or 10 years.
    - "IF YOU ARE DISABLED AT AGE 67 AND LESS THAN 12 MONTHS OF BENEFIT HAVE BEEN PAID, THE BENEFIT PERIOD WILL BE 12 MONTHS." will appear if the Benefit Period is To Age 67.
16. **Telephone Number** of the insurance department of the state in which this contract was issued may change.
17. **INSURED, AGE, SEX, CONTRACT NUMBER,** and **DATE OF ISSUE** are specific to each insured.

Disability Income Insurance, Form H-IN-GRDI (15)

The following items have been bracketed to indicate that the information may be different in different contracts or may be subject to change.

Items on Face Page

1. Service Center **address** and **telephone number** may be changed.
2. **Officers' signatures** will change if new officers are elected.
3. **INSURED, AGE, SEX, CONTRACT NUMBER,** and **DATE OF ISSUE** are specific to each insured. This wording also appears on Page 3.

Items on page 3

4. **ANNUAL PREMIUM** for the Basic Benefit is based on the insured's age, sex, occupational class, tobacco status, premium rating, monthly benefit, elimination period, and benefit period.
5. **OCCUPATIONAL CLASS:** 1A, 2A, 3A, 3M, 4A, 4M, or 5A
6. **TOBACCO STATUS:** Non-Tobacco or Tobacco
7. **PREMIUM RATING:** Standard, or a percentage ranging from 40%-100%
8. **MONTHLY BENEFIT:** $50 – $18,000
9. **ELIMINATION PERIOD:** 1 month, 2 months, 3 months, 6 months, 12 months, 24 months
    - If a Benefit Period of 12 months or less is selected, the Elimination Period selected cannot be greater than 3 months.
10. **BENEFIT PERIOD:** 6 months, 12 months, 24 months, 60 months, 10 years, To Age 67
11. **ADDITIONAL BENEFITS:** This section contains the list of all riders, and the annual premium associated with each rider, that are included with this contract. The section is not shown if no riders are attached. Possible riders are:
    FORM HR-IF-FPO (15)
    FORM HR-IO-SIO (15)
    FORM HR-IR-RDI (15)
    FORM HR-IU-SDI (15)
    FORM HR-IX-COL (15)
12. **TOTAL ANNUAL PREMIUM:** The sum of the premium for the Basic Benefit and the premiums for any additional riders.
13. **INTERVAL OF PAYMENT:** Annual, Quarterly, Monthly
14. **INITIAL PREMIUM:** The first premium paid for the Interval of Payment selected.
15. **Benefit Period Footnote:**
    - "BUT NOT BEYOND AGE 67." will appear if the Benefit Period is not To Age 67.
    - "HOWEVER, IF YOU ARE DISABLED AT AGE 67 AND LESS THAN 12 MONTHS OF BENEFIT HAVE BEEN PAID, THE BENEFIT PERIOD WILL BE 12 MONTHS." will appear if the Benefit Period is 12 months, 24 months, 60 months, or 10 years.
    - "IF YOU ARE DISABLED AT AGE 67 AND LESS THAN 12 MONTHS OF BENEFIT HAVE BEEN PAID, THE BENEFIT PERIOD WILL BE 12 MONTHS." will appear if the Benefit Period is To Age 67.
16. **Telephone Number** of the insurance department of the state in which this contract was issued may change.
17. **INSURED, AGE, SEX, CONTRACT NUMBER,** and **DATE OF ISSUE** are specific to each insured.

Future Purchase Option Benefit Rider Schedule Page, Form HR-IF-3 (15)

The following items have been bracketed to indicate that the information may be different in different riders or may be subject to change.

1. **Date of Issue of this Rider** and **Contract Number** are specific to each insured.
2. **INSURED, AGE,** and **SEX** are specific to each insured.
3. **TOTAL OPTION LIMIT:** At issue, it is the maximum cumulative amount of additional insurance that may be purchased under this rider.
4. **ANNUAL PREMIUM** for the Future Purchase Option Benefit rider is based on the insured's age, sex, occupational class, tobacco status, premium rating, monthly benefit, elimination period, benefit period, and other riders selected.
5. **PREMIUMS ARE PAYABLE TO:** The earlier of the date of the 15th contract anniversary and the contract anniversary on or after the 55th birthday.

Social Insurance Offset Benefit Rider Schedule Page, Form HR-IO-3 (15)

The following items have been bracketed to indicate that the information may be different in different riders or may be subject to change.

1. **Date of Issue of this Rider** and **Contract Number** are specific to each insured.
2. **INSURED, AGE,** and **SEX** are specific to each insured.
3. **MONTHLY BENEFIT:** $50 – $1,500
4. **ELIMINATION PERIOD:** 1 month, 2 months, 3 months, 6 months, 12 months, 24 months
    - If a Benefit Period of 12 months or less is selected, the Elimination Period selected cannot be greater than 3 months.
5. **BENEFIT PERIOD:** 24 months, 60 months, 10 years, To Age 67
6. **Benefit Period Footnote:**
    - "BUT NOT BEYOND AGE 67." will appear if the Benefit Period is not To Age 67.
    - "HOWEVER, IF YOU ARE DISABLED AT AGE 67 AND LESS THAN 12 MONTHS OF BENEFIT HAVE BEEN PAID, THE BENEFIT PERIOD WILL BE 12 MONTHS." will appear if the Benefit Period is 24 months, 60 months, or 10 years.
    - "IF YOU ARE DISABLED AT AGE 67 AND LESS THAN 12 MONTHS OF BENEFIT HAVE BEEN PAID, THE BENEFIT PERIOD WILL BE 12 MONTHS." will appear if the Benefit Period is To Age 67.
7. **ANNUAL PREMIUM** for the Social Insurance Offset Benefit rider is based on the insured's age, sex, occupational class, tobacco status, premium rating, monthly benefit, elimination period, and benefit period.

Residual Disability Benefit Rider Schedule Page, Form HR-IR-3 (15)

The following items have been bracketed to indicate that the information may be different in different riders or may be subject to change.

1. **Date of Issue of this Rider** and **Contract Number** are specific to each insured.
2. **INSURED, AGE,** and **SEX** are specific to each insured.
3. **ANNUAL PREMIUM** for the Residual Disability Benefit rider is based on the insured's age, sex, occupational class, tobacco status, premium rating, monthly benefit, elimination period, benefit period, and other riders selected.

Supplemental Disability Income Benefit Rider Schedule Page, Form HR-IU-3 (15)

The following items have been bracketed to indicate that the information may be different in different riders or may be subject to change.

1. **Date of Issue of this Rider** and **Contract Number** are specific to each insured.

2. **INSURED, AGE,** and **SEX** are specific to each insured.
3. **MONTHLY BENEFIT:** $50 – $18,000
4. **ELIMINATION PERIOD:** 1 month, 2 months, 3 months, 6 months, 12 months, 24 months
    - If a Benefit Period of 12 months or less is selected, the Elimination Period selected cannot be greater than 3 months.
5. **BENEFIT PERIOD:** 6 months, 12 months, 24 months, 60 months, 10 years, To Age 67
6. **Benefit Period Footnote:**
    - "BUT NOT BEYOND AGE 67." will appear if the Benefit Period is not To Age 67.
    - "HOWEVER, IF YOU ARE DISABLED AT AGE 67 AND LESS THAN 12 MONTHS OF BENEFIT HAVE BEEN PAID, THE BENEFIT PERIOD WILL BE 12 MONTHS." will appear if the Benefit Period is 24 months, 60 months, or 10 years.
    - "IF YOU ARE DISABLED AT AGE 67 AND LESS THAN 12 MONTHS OF BENEFIT HAVE BEEN PAID, THE BENEFIT PERIOD WILL BE 12 MONTHS." will appear if the Benefit Period is To Age 67.
7. **ANNUAL PREMIUM** for the Supplemental Disability Income Benefit rider is based on the insured's age, sex, occupational class, tobacco status, premium rating, monthly benefit, elimination period, and benefit period.

Cost of Living Indexing Benefit Rider Schedule Page, Form HR-IX-COL (15)

The following items have been bracketed to indicate that the information may be different in different riders or may be subject to change.

1. **Date of Issue of this Rider** and **Contract Number** are specific to each insured.
2. **INSURED, AGE,** and **SEX** are specific to each insured.
3. **ANNUAL PREMIUM** for the Cost of Living Indexing Benefit rider is based on the insured's age, sex, occupational class, tobacco status, premium rating, monthly benefit, elimination period, benefit period, and other riders selected.

Future Purchase Option Benefit Rider, Form HR-IF-FPO (15)

The following items have been bracketed to indicate that the information may be different in different riders or may be subject to change.

1. **Date of Issue of this Rider** and **Contract Number** are specific to each insured.
2. **Officers' signatures** will change if new officers are elected.

Cost of Living Indexing Benefit Rider, Form HR-IX-COL (15)

The following items have been bracketed to indicate that the information may be different in different riders or may be subject to change.

1. **Date of Issue of this Rider** and **Contract Number** are specific to each insured.
2. **Officers' signatures** will change if new officers are elected.

Social Insurance Offset Benefit Rider, Form HR-IO-SIO (15)

The following items have been bracketed to indicate that the information may be different in different riders or may be subject to change.

1. **Date of Issue of this Rider** and **Contract Number** are specific to each insured.
2. **Officers' signatures** will change if new officers are elected.

Supplemental Disability Income Benefit Rider, Form HR-IU-SDI (15)

The following items have been bracketed to indicate that the information may be different in different riders or may be subject to change.

1. **Date of Issue of this Rider** and **Contract Number** are specific to each insured.
2. **Officers' signatures** will change if new officers are elected.

Residual Disability Benefit Rider, Form HR-IR-RDI (15)

The following items have been bracketed to indicate that the information may be different in different riders or may be subject to change.

1. **Date of Issue of this Rider** and **Contract Number** are specific to each insured.
2. **Officers' signatures** will change if new officers are elected.

Any minor typographical errors that are discovered in these forms will be corrected. In the future, there is a possibility that the type style may be changed, which could impact the pagination and the Table of Contents and Index page reference numbers.

THRIVENT FINANCIAL FOR LUTHERANS

STATEMENT OF VARIABILITY DTD 8-27-15

Individual Disability Income Insurance Application, Form 28848

Lower Right Hand Corner. Bracketed for internal administrative use such as internal tracking purposes, system document name or codes, and for version control.

Simplified Issue Individual Disability Income Insurance Application, Form 28849

The following items have been bracketed to indicate that the information may be different in different applications or may be subject to change:

In **Section 3-Product Information**, the range for the [3 months] Elimination Period is 1 month, 2 months, 3 months, 6 months, 12 months, or 24 months. The range for the [60 months] Benefit Period is 6 months, 12 months, 24 months, 60 months, 10 years, or To Age 67.

Please note that if a Benefit Period of 12 months or less is shown, the Elimination Period cannot be greater than 3 months.

Lower Right Hand Corner. Bracketed for internal administrative use such as internal tracking purposes, system document name or codes, and for version control.

Supplement to Application for Insurance – Medical Details, Form 28855

Lower Right Hand Corner. Bracketed for internal administrative use such as internal tracking purposes, system document name or codes, and for version control.

Conditional Temporary Individual Disability Income Insurance Agreement and Receipt for Payment, Form 28857

Lower Right Hand Corner. Bracketed for internal administrative use such as internal tracking purposes, system document name or codes, and for version control.

Supplement to Application for Insurance - Prescription Drugs, Form 28858

Lower Right Hand Corner. Bracketed for internal administrative use such as internal tracking purposes, system document name or codes, and for version control.

Supplement to Application for Insurance – Replacement and Other Coverage, Form 28859

Lower Right Hand Corner. Bracketed for internal administrative use such as internal tracking purposes, system document name or codes, and for version control.

Endorsement Eliminating Coverage, Form 28861

The bracketed information may contain alternate text subject to applicable state laws, to allow for the flexibility to exclude from coverage under the disability policy : (a)injuries sustained while participating in activities associated with certain avocations/aviation, including, but not limed to the following activities disclosed in the application and/or identified during the underwriting process, scuba diving, race car driving, aviation, and/or (b) a disability contributed to or caused by any injury, disease, or medical disorders or conditions, including treatment, surgery and complications thereof, disclosed in the application and/or identified during the underwriting process of the Company.

Bracketed information shown:

[Disease or disorder of the left knee, including any complications thereof]
[Injury sustained while operating or riding in a motor vehicle engaged in racing or speed-testing]

Lower Right Hand Corner. Bracketed for internal administrative use such as internal tracking purposes, system document name or codes, and for version control.

Disability Income Application Change, Form 28872

The bracketed information below the "I change my application with Thrivent Financial as follows:" allows for the flexibility to make changes to answers provided in the application. The changes include, but are not limited to additions or deletions of riders, changes in benefit amounts, elimination periods and benefit periods. We also intend for this area to allow for the flexibility to provide explanations for incomplete answers or for completing sections that were omitted during the initial taking of the application.

Bracketed information shown:

[Answer to Question 3b in Section 8 is no.]
[The Residual Disability Benefit Rider has been deleted.]
[The Base Disability Income Benefit elimination period has been changed to 6 months.]

Lower Right Hand Corner. Bracketed for internal administrative use such as internal tracking purposes, system document name or codes, and for version control.

Statement of Good Health, Form 28874

Lower Right Hand Corner. Bracketed for internal administrative use such as internal tracking purposes, system document name or codes, and for version control.

Supplement to Application for Insurance – Application Action, Form 28875

Lower Right Hand Corner. Bracketed for internal administrative use such as internal tracking purposes, system document name or codes, and for version control.

Supplement to Application for Insurance – Moving Traffic Violations, Form 28876

Lower Right Hand Corner. Bracketed for internal administrative use such as internal tracking purposes, system document name or codes, and for version control.

Individual Disability Income Insurance Contract Reinstatement Application, Form 28877

Lower Right Hand Corner. Bracketed for internal administrative use such as internal tracking purposes, system document name or codes, and for version control.

Any minor typographical errors that are discovered in these forms will be corrected. In the future, there is a possibility that the type style may be changed, which could impact the pagination and the Table of Contents and Index page reference numbers.